

HEALTH SECURITY ACT OF 1993

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PT. 2

Health Security Act of 1993, S. Hrg....

HEARINGS

BEFORE THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING THE ADMINISTRATION'S PROPOSED HEALTH SECURITY
ACT, TO ESTABLISH COMPREHENSIVE HEALTH CARE FOR EVERY
AMERICAN

OCTOBER 20, NOVEMBER 8, 9, 10, AND 16, 1993

PART 2

Printed for the use of the Committee on Labor and Human Resources



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HEALTH SECURITY ACT OF 1993

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HEALTH ALLIANCES: BUILDING A STRUCTURE FOR REFORM

WEDNESDAY, OCTOBER 20, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Metzenbaum, Harkin, Mikulski, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, Thurmond, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

We are delighted to welcome Ms. Judith Feder, and we know that you have limited time, so we will suspend the opening comments.

I mentioned earlier that I would like to focus on the different alliances or arrangements that have been suggested in the various approaches that have been put out, and then hopefully we can deal with the power of the board on Friday. At least, that is my hope; I do not know whether we will be able to stick with that plan or not.

We would be glad to hear from you at this time.

[The prepared statements of Senators Kennedy, Dodd, Mikulski, and Thurmond follow:]

PREPARED STATEMENT OF SENATOR KENNEDY

A central part of the President's comprehensive health reform plan is the creation of health alliances that will make contracts with insurance plans to provide coverage for large numbers of individuals and businesses in various geographical areas.

Under the President's plan, health alliances have important functions. Because of their strength in numbers, they provide small businesses and individuals with much of the same bargaining power and administrative efficiency enjoyed today by the largest corporations. Individuals will be able to choose among the plans to pick the one they prefer, rather than have employers make the choice. Alliances eliminate the notorious exclusions for pre-existing conditions, and other unfair tactics. Most important, in conjunction with other features of the bill, they restructure the health insur-

ance industry to create more competition, so that market forces can work to bring costs down.

The basic concept of health alliances is a central part of other reform plans as well, including the Senate Republican proposal and the House Republican plan. At the same time, there are important differences over how the alliances should be structured, and our hearing today will explore these issues.

Four questions seem to be most important. The first is the size of the regional alliances. All the proposals make the alliances the purchasing agent for the self-employed and unemployed. The differences arise over which businesses should be required to participate in the alliances. The Administration's proposal would include firms with up to 5,000 employees, or about 70 percent of the population. Other proposals would set the cut-off as low as 100 employees, which would still account for more than 50 per cent of the population.

The second issue is whether to allow more than one alliance in a given region. Under the Administration's plan, each regional alliance is the sole organizer of insurance plans for the covered population in its geographic area. Other proposals allow for multiple alliances.

Third, there is concern that the alliances may be too big and bureaucratic—more like regulatory bodies than purchasing cooperatives. In large part, this issue turns on how the alliances are organized and the functions they are assigned.

Finally, there is concern that the global budget in the Administration's plan is inconsistent with the concept of using competition to control costs.

Powerful interests have a strong stake in each of these issues. But the American people have the greatest interest of all at stake—a health care system that serves their needs well and provides the health security they deserve.

I welcome our witnesses, and I look forward to their testimony.

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, this morning's hearing is the first to focus on the technical aspects of the administration's health care proposal. Until now, we have given our attention to the impact of the proposed plan—on patients, providers, employers, and the economy. It's now time to roll up our sleeves and examine the mechanics of reform.

I look forward to learning from our expert panel more about the central feature of the Clinton plan—the health alliances. We will rely heavily on these new structures to achieve the President's six principles—security, savings, simplicity, choice, quality, and responsibility. This morning and over the coming months, we will examine the proposed alliances to see how well they will help us achieve these principles.

Bipartisan support for concept of alliances

As we begin the discussion, I think it's important to note that both parties have adopted the concept of alliances as a central feature of reform. While the alliances in the various proposals differ in size and responsibility, plans supported by both parties include these purchasing structures. The Clinton proposal, Senator

Chafee's plan, Congressman Cooper's bill all rely on alliances to correct problems in today's insurance market.

Experience with alliance-type structures in California, Minnesota, and among Federal employees suggests that large purchasing pools can positively affect cost, quality, and choice.

Alliances appear able to correct fundamental problems in today's insurance market, such as the high administrative costs and other problems faced by individuals and small businesses. Alliances can bring together consumers and employers to negotiate for high quality care. They provide choice of plans. They force health plans to compete for members on based on quality and cost. And they can assure portability of coverage, so that when individuals change or lose their jobs, their insurance coverage continues.

The alliances also have the potential to reach those individuals in areas underserved by the health care system. The regional alliances can contract with health plans to expand their areas of coverage, to include those who are currently at a disadvantage. This will help ensure that all individuals have access to the proposed benefits package that we seem to agree all individuals deserve.

Areas of disagreement

While I have stressed that widespread support exists for the concept of alliances, there is disagreement on the specifics. The size and regulatory power of the alliances are two areas that generate vigorous debate.

Some argue that the alliances proposed by the Clinton plan create too much bureaucracy, while others argue that their role is limited and necessary. Some would like participation to be voluntary, while others fear that only high-risk individuals will enroll in voluntary alliances.

The ultimate design and function of these alliance clearly will determine how well we achieve the broad goals of health care reform. Today and in the coming months, we will examine and debate the details of health alliances with these goals in mind.

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning Mr. Chairman and distinguished witnesses. I would like to first thank the chairman for putting this hearing together.

I'm happy we are holding this hearing because I've got questions and I want answers, and I think there are lots of others who feel just like I do.

For me the issue is not the overriding questions of the need for reform or the need for universal coverage. Those are givens for me.

My concerns have to do with how this thing is going to work.

I don't want this system to be too complicated.

I want the focus to stay on the best way to deliver services. I hear too much about these alliances being focused on control. And I keep hearing about the marketplace driving down costs. Those things have their place, but they miss the point.

The point, the mission, is the need to reinvigorate the health care system.

I'm concerned about cost, but I'm more concerned about care. Community health care for the underserved in either rural or

urban areas is by its nature high-cost. But its also where the need for care is greatest.

We should never lose sight of what we are trying to accomplish here. And the administrative structure we build to deliver this new system needs to promote that purpose.

Just holding this hearing takes us past the rhetoric of the need for reform and gives us a chance to ask nuts and bolts questions like: How will this system be put together? How will the American people interact with this new mechanism? How will decisions that affect the health care of the American people be made? How will problems be resolved? How will access be improved?

I have lots of questions about the administrative structure. I'm worried about how to keep from building new barriers to care in the form of a new bureaucracy.

I want to be sure that administrative cost will be as low as possible but I also want to be sure we will build a structure which assures equity and quality and responsiveness to the health care needs of the American people.

I want to know what the States are saying and what the cities are saying and what the local communities are saying about how to go beyond a list of covered services in the benefits package and get to problems of access and service delivery. That is what these alliances should be about, not just rate-setting and resolving appeals on questions of coverage.

Lots of people in this town are worried about cutting the deficit, we need a few more who are worried about cutting the death rate. That's my concern.

In order to do that we have to build a whole new infrastructure for community-based service delivery. I want to know how these alliances will help to make sure that happens.

So as I said, I'm very pleased that we are holding this hearing today, and I'm looking forward to the testimony to be presented.

Thank you Mr. Chairman.

PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman: It is a pleasure to be here this morning to receive testimony concerning the role of Health Alliances in Health Care Reform. I would like to join my colleagues in extending a warm welcome to our witnesses here today.

As you know, the Health Alliances are meant to act as a facilitator between health plans and individual purchasers of health insurance coverage. These alliances will contract with health plans to provide the required benefits package, and provide a simplified, uniform means for individuals to choose between plans.

According to the President's outline, the alliance may be operated as a non-profit corporation, an independent state agency, or a state executive agency. Further, it will serve all eligible persons who live in a designated geographic area.

Mr. Chairman, I believe that in a pure managed competition approach, health alliances may be able to act as a necessary, unbiased conduit between health insurance plans and consumers. However, I am concerned that health alliances will only add to the bureaucracy of the health care system.

I am also concerned that the President's proposal goes beyond simply providing a facilitator between providers and consumers. The Health Security Act appears to be giving alliances what will amount to regulatory command and control authority to enforce premium prices on insurance plans and exclude plans with higher premiums.

The alliances will also be able to determine what kinds of health plans would be allowed to compete by limiting the number of fee for service plans in an alliance. This limitation would not promote competition; and it is only through competition that cost-effectiveness and quality health care can be achieved.

Again, Mr. Chairman, I would like to welcome our witnesses here today, and I look forward to their testimony.

STATEMENT OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. FEDER. Thank you, Mr. Chairman.

It is indeed a pleasure to be here as we move forward on our joint commitment to comprehensive health reform. As you indicated, our focus this morning is on the structure of reform. This committee is all too familiar with the problems we are trying to address with that structure—the insecurity of Americans with respect to their health insurance; the skyrocketing health care costs, and the complexity of a system that essentially leaves consumers at the bottom of the heap.

As we talk about alliances today, what we want to talk about is how we put consumers back in charge in restructuring our health care system. Let me describe that structure to you as the President's plan would put it forward.

First and most fundamental, the reformed health insurance system must be grounded in a Federal-State-private sector partnership. The President's philosophy is that the Federal Government's appropriate role is to provide all citizens with a guarantee of health security that includes real cost control, quality and choice; to set out what is expected of our private health care system in terms of measurable outcomes for delivering on these guarantees; establish a framework for reformed markets in which the private health care system can operate to deliver these guarantees, and then get out of the way and let the system work.

The job of building the system will be accomplished through States, with each State adopting a plan for implementing and enforcing the nationally-guaranteed health care reforms, built in large part around new health alliances.

As we turn to alliances, I want to be very clear from the outset about what they are not. I will talk more about it later, but they are not regulatory agencies. Rather, they are consumer-run purchasing pools.

Mr. Chairman, as you indicated, there has been some confusion about what alliances are and what they will do, and I want to describe the five important functions that we believe alliances will perform.

First and foremost, they give purchasing clout back to consumers. If you look at the chart behind you, it will illustrate how it is that we think alliances will achieve this goal.

Right now, individual consumers, small businesses and even many not so small businesses are at a terrible disadvantage in the insurance market, as they operate on a very fragmented basis. It is not they who make choices about their health care benefits; rather, it is the insurance industry or insurance companies, who essentially are able to decide who can get benefits, what benefits they can get, and what price they will pay.

Bringing individuals and businesses, all but the very largest businesses, into a common pool changes all that, if you will; it changes the balance of power in the marketplace. Now we have one pool, not a whole fragmented system, but one pool, in which individuals are choosing from assorted health plans. We have the health plans at the top of the chart.

The plans are now bidding for the opportunity to provide the guaranteed benefit package to all the individual consumers in that pool's health alliance. The plans will, of course, be operating according to new rules—no more fine print regarding pre-existing conditions, exclusions, etc. They all offer the guaranteed benefit package, offer it to all comers, and do so at community rates.

In every community, there will be one health alliance, and all health insurance for the guaranteed package must be sold through that alliance.

The second function of an alliance is to make choice meaningful. It is not enough in this marketplace to simply have choices available to consumers. Consumers need information to make wise choices. They need to know not only what the premium charge is for a plan, but what their out-of-pocket obligations will be for deductibles or other cost-sharing. They need to know about the doctors and hospitals and other providers on whom the plan is relying. They need to know about the quality of care in the plan. And they need to know how satisfied people have been with the plan.

There is a lot of concern about having information on what a plan will do and how well it will serve people, and that information must be available; it is the job of the alliance to provide it to us as consumers.

The third function of the alliance is to make the private health insurance market work. It is not the job of the alliance to certify health insurance plans. That is a regulatory function and that, under our proposal, would be dealt with by the States. Rather, the alliance is the health care market in which health plans will have no choice but to compete by offering the best possible health care for the lowest possible price. That means that health insurance plans will need to be more efficient in paying our claims, and they will need to work more closely with doctors and other providers to help develop systems for coordinating care and safeguarding quality.

The fourth function of the alliance is to reduce administrative burdens for employers. Many of the functions that will be performed in the alliance are not new functions—enrolling people in plans, getting information and choosing plans. Those functions today, though, are on the backs of the employers.

For a small business especially, the costs and other burdens of providing health insurance—finding a plan, coordinating benefits for spouses, understanding the fine print—can be overwhelming. Health alliances will relieve employers of these burdens. Instead of selecting and providing health plans for their workers, employers in health alliances will only be responsible for contributing their share of the premium to the alliance.

And now the fifth function of the alliance—to protect affordability. First, alliances do that by becoming the forums in which the new market competition forces will operate to control overall health care costs. This market competition will be backed up by enforceable premium caps set at the national level.

The second aspect of affordability that the alliance takes charge of is to administer a system of discounts for low-income individuals and families, and for low-wage businesses. By performing that function, making those discounts available, they enable everybody to play and to pay their fair share.

Now, as I promised, I want to turn with somewhat more detail to what alliances will not do. Alliances will not be regulatory agencies. They are run by employers and consumers. They will follow the rules set by the Federal Government and States to govern our health care system, not make them.

The primary function of health alliances will be to facilitate health care markets in ways that promote cost-saving competition, while protecting the interests and health security of consumers.

Second, alliances will not compete with each other. Each alliance drawn will establish a market for health plan competition based on quality, service, and efficiency. If more than one alliance were established in a community, health plans would be able to select which neighborhoods or populations to serve by selecting the alliance in which to do business.

Finally, health alliances will not eliminate a role for very large corporations who wish to continue operating their own health plans. Employers with more than 5,000 full-time workers nationwide may establish corporate alliances that will fulfill the national guarantees in ways similar to health alliances.

Mr. Chairman, the concept of health alliances appears, as you indicated, in many of the health reform bills introduced in this Congress as well as in the President's health reform plan. We believe that reestablishing large health insurance market pools and shifting clout back to consumers is fundamental to effective reform, and that health alliances will permit us to achieve these goals.

Thank you.

[The prepared statement of Ms. Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER

Mr. Chairman and members of the committee: There is a groundswell of support for health reform from the American people. As we set out to answer this call to action, we must start by recognizing that this consensus stems from the plain fact that our health insurance and health care delivery systems suffer from major flaws that threaten our health security. The reasons for this are well known to this committee.

No longer is lack of health security a problem only for a minority of Americans who somehow fall through the cracks. It is the majority of Americans, most of whom have health insurance, who have become afraid that it will not be there when they need it.

Today, insurers are free to price the sick out of the market. There is no guarantee that the health insurance coverage we have today will be there tomorrow, whether because we lose our job, change our marital status, or get sick.

We also are increasingly lacking choice. Decisions about which health plans are available for enrollment, and what benefits are offered, often are not made by the families whose health care will be affected, but by employers. This arrangement compromises not only choice, but also continuity of care.

Quality also is threatened as patients with ill-defined health problems bounce from specialist to specialist, incurring costs for many expensive tests and procedures before they find the care they need. And practitioners lack data on what works and what constitutes quality care. For the most part, health plans today are not held accountable for the quality of care their providers render, for the efficiency of their customer service, or for their ability to organize hospitals, doctors, and other providers to achieve these ends within a budget.

In light of these problems, it is not surprising that a large majority of Americans believe the system needs a complete overhaul, think that the cost of care in this country is much higher than it should be, worry that they will have health care costs that will not be covered, and are concerned about losing coverage if they change jobs. This is simply unacceptable—we must put the consumer in the driver's seat.

Mr. Chairman, the demand for reform is a rational response to an irrational system. To address this demand the President has outlined six principles on which health reform must be founded: security, simplicity, savings, quality, choice, and responsibility. The First Lady and Secretary Shalala, in their testimony before this committee, already have presented the American Health Security Plan's reforms for our health care system. Today, I will focus my testimony on the role of the health alliance as a key building block for reform.

THE FEDERAL/STATE/PRIVATE SECTOR PARTNERSHIP

First, and most fundamental, the reformed health insurance system must be grounded in a Federal/State/private sector partnership. Each of these partners is best suited to take on certain roles. The President's philosophy is that the Federal Government's appropriate role is to: provide all citizens with a guarantee of health security that includes real cost control and quality; set out what is expected of our private health care system, in terms of measurable outcomes, for delivering on these guarantees; establish a framework for reformed markets in which the private health care system can operate to deliver these guarantees; and then get out of the way and let the system work.

The President also believes that States, communities, and private consumers, doctors, hospitals, and health plans are best suited to anticipate and respond to local circumstances and needs and to make health care decisions that make sense for them. Health care is a local industry and a personal service in which one size will not fit all. Therefore, a structure for local decision making must be established that will provide the nationally established guarantees while preserving local flexibility and responsiveness. This will be accomplished through States, with each State adopting a plan for implementing and enforcing the nationally guaranteed health care reforms, built in large part around new health alliances.

ROLE OF THE HEALTH ALLIANCES

Health alliances will be large purchasing pools formed to represent the interests of consumers and employers. While States will provide for alliances to be established, they will be run by consumers and employers. All health insurance will be sold through health alliances.

Mr. Chairman, there has been some confusion about what alliances are and what they will do. Let me be clear. Under the Health Security Plan, health alliances will have five important functions:

1. Giving purchasing clout back to consumers

Anyone, especially a single person or family or a small business owner, who has tried to bargain with today's insurance industry knows all too well where the market clout in our system rests today. Health insurance companies today can and do refuse coverage, cancel coverage, or hike premiums on short notice based on our health, our age, where we live or where we work. Under the Health Security Plan, these unfair practices will be illegal. Health alliances will play an important role in making this legal protection a reality.

In every community, there will be one health alliance (States may draw alliance boundaries, but may not subdivide a metropolitan area within a State) and all

health insurance must be sold through health alliances. Therefore, any health insurance company that wants to do business in a community is going to have to open its doors to everybody. There will be no more selective enrollment and disenrollment. In addition, because all consumer and employer premiums will be paid to the health alliances, and then passed on to health plans, community rating will be automatically enforced. Any consumer complaints about a health plan can be taken to an ombudsman that will be employed by each alliance. Additionally, health plans in alliances will establish consumer grievance and appeals procedures that meet federal standards.

2. Making choice meaningful

In States that do not elect to establish a single-payer system, health alliances will offer people a choice of health plans, including at least one fee-for-service plan. People—not their employers, not bureaucrats, not insurance companies—will select their own health plans. Every year, people will sign up for the health plan of their choice through their local health alliance. They can stay with that health plan as long as they like, even if they lose their jobs or change jobs to work for another employer within the alliance. Or, they can change coverage to another health plan offered through the alliance during any open enrollment period. The choice will always be theirs and theirs alone.

The health alliance will do more than simply present an array of choices to people, however. It also will collect and provide information to help people make informed choices. The health alliance will collect from each plan information about its premium; deductibles and copays; the doctors, hospitals, and other providers available to its enrollees; the quality of care rendered by these providers; and indicators of customer satisfaction (for example, how long it takes to make a doctor's appointment.) All of this information will be made available to the people served by the health alliance. Then, armed with this information, people can choose a health plan that will be best for themselves and their families.

3. Making private health insurance markets work

In order to sell health insurance in a community, health plans will have to register with the health alliance. To sell in an alliance, a health plan will have to be licensed by the state, which means it will have to cover the guaranteed comprehensive benefits, set premiums according to community rating, and so on. Health plans will determine their premiums through a competitive bidding process. The Plans will submit their bids to the health alliance, which will be required to accept all qualified plans with premiums at or below 120 percent of the premium cap. The health alliance will then publish the premiums for all consumers to see. Consumers will weigh the cost, quality, and consumer satisfaction data they have on all plans as they select their own coverage.

In this reformed market within each health alliance, plans will have no choice but to compete by offering the best possible health care for the lowest possible price. That means health insurance plans will need to be more efficient in paying our claims. And they will need to work more closely with doctors and other providers to help develop systems for coordinating care and safeguarding quality. Where the market needs additional support to work well, health alliances also can encourage existing health plans to move into underserved areas, and can assist the development of new health plans formed by local providers.

4. Reducing administrative burdens for employers

For a small business, especially, the cost and other burdens of providing health insurance—finding a carrier, coordinating benefits with the plans of working spouses, understanding the fine print—can be overwhelming. Health alliances will relieve employers of these burdens. Instead of selecting and providing health plans for their workers, employers in health alliances will only be responsible for contributing their share of the premium to the alliance. The alliance will inform employers of the amount of their required contribution and make arrangements for periodic collections. Alliances also will determine individual premium contributions.

5. Protecting affordability

Finally, health alliances will assume two key responsibilities in order to secure affordable health care for all Americans. First, health alliances will be the forum in which the new market competition forces will operate to control overall health costs. This market competition will be backed up by enforceable premium caps, set at the national level. When health alliances accept premium bids from plans, they will check to see that bids are consistent with these enforceable limits; automatic reductions are triggered when premiums are too high.

Health alliances also will administer a system of discounts for low-income individuals and families and for low-wage businesses. Individuals and families will self-declare their eligibility for these discounts based on their income at the beginning of each year. Alliances will then operate a reconciliation system at the end of each year to account for any mid-year changes in income. Similarly, employers will declare their eligibility for discounts, and reconcile accounts at year-end. The smallest businesses with the lowest wages will pay no more than 3.5 percent of payroll to cover all their employees. No business in a health alliance will be required to pay more than 7.9 percent of payroll. Employee contributions will be collected through payroll withholding and paid to alliances periodically along with the employer contribution.

WHAT ALLIANCES WILL NOT DO

Finally, it is worth a moment to note what alliances will not do. Alliances will not be regulatory agencies. They are run by employers and consumers. They will follow the rules set by the Federal Government and States to govern our health care system, not make them. The primary function of health alliances will be to facilitate health care markets in ways that promote cost-saving competition while protecting the interests and health security of consumers.

Second, alliances will not compete with each other. Each alliance drawn will establish a market for health plan competition based on quality, service and efficiency. If more than one alliance were established in a community, health plans would be able to select which neighborhoods to serve by selecting the alliance in which to do business.

Finally, health alliances will not eliminate a role for very large corporations who wish to continue operating their own health plans. Employers with more than 5000 full time workers nationwide may establish corporate alliances that will fulfill the national guarantees in ways similar to health alliances. Corporate alliances will have to offer employees a choice of plans that cover the guaranteed benefits for premiums that are within the established limits. They also will have to provide for periodic open enrollment periods, establish grievance procedures and other consumer protections, and so on.

Corporate alliances will not compete with health alliances—a large corporation of sufficient size is a naturally-formed insurance pool, but it will not be allowed to compete to insure people who are not employees or their dependents. Preserving the option for corporate alliances will permit those large employers with extensive experience and a track record of successful innovation to continue their efforts.

CONCLUSION

Mr. Chairman, the concept of health alliances appears in many of the health reform bills introduced already in this Congress, as well as in the President's health reform plan. We believe that re-establishing large health insurance market pools and shifting clout back to consumers is fundamental to effective reform. Health alliances will permit us to achieve these goals.

The CHAIRMAN. We will try to do 5-minute rounds. I apologize to the members, and we will submit additional questions. I will ask staff to keep the time.

I am concerned that the American people do not understand the concept of the alliance or of AHPs in the Clinton plan and also in the Chafee plan. So let me propose an analogy and see if you agree with me.

Let us compare an alliance to an American supermarket, and the health plans to the array of different brands of orange juice on the supermarket shelves. Everybody in the geographic area goes to the neighborhood supermarket to shop for groceries, just the way everyone in a geographic area would belong to an alliance to shop for their health care.

The supermarket organizes the groceries on the shelf the way an alliance organizes different health plans for the members of the alliance.

Let us use the analogy of orange juice to compare with the accountable health plans. Orange juice companies supply orange juice

to the supermarket. This is like different HMOs, insurers and health plans offering to provide health care.

Then the supermarket, because of its size and buying power, can obtain and offer the best prices to the consumers, just as the health plans in the alliance will offer the best prices to the consumers. And because the orange juice company deals with the large supermarket, it can save money on administration, sales, and delivery prices, thereby enabling it to reduce its price further. And the supermarket offers a range of different orange juices that meet the basic standards of quality. The consumer can go in, read the different labeling indicators in one place and find out the various nutritional components in one or the other. The supermarket makes it easy to choose among the range of orange juices it offers. It puts all the orange juices together on the shelves, lists the competing prices; the label on the container describes the nutritional information and other important factors consumers want to know when making their decisions. And thus the consumer maximizes choice in purchasing orange juice. And if the consumer is dissatisfied or gets a faulty container of orange juice, he comes back to the supermarket, which helps him make an exchange.

The supermarket represents him or her in dealing with the orange juice company.

This is obviously a very rough analogy. For instance, the Clinton plan does not contemplate the alliance running its own health plan whereas in the example, the supermarket can offer its own brand of orange juice. But in trying to have these alliances understood by American consumers in the towns of New Bedford and Fall River, or Springfield or Lawrence, MA, can you react to that analogy?

Ms. FEDER. I think the analogy works very well. I would only respond to it in a couple of ways. First, I think it has to do with the urgency of creating a supermarket in health insurance. As you well know, health care is not orange juice, and the lack of a supermarket right now or of that kind of approach really puts consumers at terrible risk in the marketplace since, when they are choosing on their own, without the benefit of that marketplace, they are faced with choices of plans that may not cover them when they need it, that impose enormous market costs, enormous risk selection costs, and other problems. So there is that urgency.

Second, I think I would place particular emphasis on the role of the nutritional labeling, as you mentioned, because if you pick the wrong brand of health care as opposed to the wrong can of orange juice, you can be in serious trouble. So the need for this kind of marketplace is, again, I think, a critical factor.

The CHAIRMAN. We had a hearing in Fall River where some members of the business community were talking about a new level of bureaucracy. How do you respond to that question in people's minds? Are we just adding another layer of bureaucracy, and is this really efficient, and can it ensure that there will be cost-savings as far as the average working family?

Ms. FEDER. Yes, I think the analogy again works very well here, because essentially what the alliance is doing is replacing the waste and inefficiency in the current, unfettered marketplace. We know that the administrative costs of small group insurance are taking in the neighborhood of 40 cents on the dollar. The alliance

can substantially reduce that cost. And we are replacing functions, as I indicated in my testimony, that now fall on the backs of employers. So I think it is replacing and making the marketplace more efficient.

The CHAIRMAN. Again for the small business, will this mean better information for them to be able to make judgments and decisions? Will it be easier for them and less costly trying to evaluate between different competing programs of 1,500 different insurance companies at the present time?

Ms. FEDER. I think the key here is that essentially, it will not be those businesses who have to make those choices anymore. Essentially, their job will be to make the contributions, and we the consumers will be making the choices. I think it will be much easier and more efficient for all of us.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Dr. Feder, I know time is short. I just want to call attention to my own chart that I put up, which I believe shows in a little more detail how I would view the health alliances working.

I feel strongly that such an enormous alliance is very troubling. In fact, in Kansas, there are only six companies that have 5,000 or more employees. Everyone else would be in. Finally, you keep saying that the consumers will run it, but as a matter of fact, they are rather limited in what they can do and the choices they may have.

I think there is a risk of a monopolistic regulatory power that can grow with these alliances and that does not serve the delivery system well that you are trying to achieve and that many of us here would like to try to achieve.

The alliances in the Republican Health Task Force plan are not mandatory. Rather, they are voluntary cooperative alliances that would be 100 employees or less that can come together. It is not a mandatory arrangement.

Just to lay out some of the concerns that I have, the alliance would be an exclusive franchise for a given region, such as Kansas or Vermont. Most of our States would have just one alliance that would comprise the whole State. It is established by State Governments. The Governor, I assume, would do the appointing. I think that is not yet clearly detailed, is it?

Ms. FEDER. There is flexibility for the State as to how that is handled.

Senator KASSEBAUM. But most of the rest of the alliance system is very detailed and specific. For example, your plan is carefully detailed as to exactly how consumers will be treated and regulated by the alliance, under the regulation of the Department of Labor as the overseer. Is that correct?

Ms. FEDER. The Department of Labor focuses primarily on the corporate alliances and has some role with respect to enforcing the employer mandate, but there is primarily an HHS function in terms of overseeing the health alliance.

Senator KASSEBAUM. What if, for instance, I would want to choose a different plan than those plans approved by the alliance? What if my insurance has been with one insurer, and that insurer

is not laid out by the alliance? Can I still work through the alliance, or will I have to give up my choice?

Ms. FEDER. Let me clarify what it is that the alliance is doing with respect to, as you indicated, approving plans. It really does not have a role there. The State would be certifying health plans, guaranteeing that they are providing a guaranteed package, that they are financially solvent, that they have quality assurance mechanisms, that they are indeed plans that we can count on and not risk selecting. And then the alliance essentially accepts bids from all qualified plans. There may be a maximum price constraint on plans that come into an alliance, but the alliance is not picking and choosing among the plans; it is quite open.

Senator KASSEBAUM. Well, then, let me ask you, Dr. Feder, who does decide what the quality of the plans are that are being offered? The State?

Ms. FEDER. That is correct.

Senator KASSEBAUM. Who in the State?

Ms. FEDER. I do not know that we have specified the agency in the State, but it is a State responsibility, as it is today, to certify insurance plans.

Senator KASSEBAUM. So it could be the current insurance commissioner's office and so forth?

Ms. FEDER. I believe that is correct, but again, we have laid out the new standards. The standards that must be enforced are clearly specified in the statute, or would be.

Senator KASSEBAUM. Let me just ask you why you picked 5,000. Why have you gone to such a large, as I said, really monopolistic, and regulatory structure?

Ms. FEDER. You raised the size of the corporation or the business involved and also whether it should be voluntary or a single pool in an area. I think we have had many considerations in that regard. With respect to the size of employer who is in the alliance, our primary goal was to reestablish a community across which risks could be shared, essentially to recreate the broad pool that insurance is intended to be. And in order to do that, the pool must be relatively large.

At the same time, we recognize that there are large businesses who operate across State lines, and some very large businesses who have been quite innovative in developing new health insurance plans. So we wanted to leave the opportunity for those corporations to continue to provide that innovation and to have the flexibility to operate in that regard.

When it comes to whether or not there should be competing alliances in an area, or a choice of alliance, our belief is that the competition in this system needs to focus at the health plan level; that if instead, we have competing alliances, we run the risk of recreating the current system in which businesses or individuals are able to segment themselves into high-risk and low-risk pools and go back to having the kind of discrimination based on health status that we are all committed to avoiding. So that has been our thinking.

Senator KASSEBAUM. Thank you. My time is up.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Thank you, Mr. Chairman.

Dr. Feder, I was concerned about one comment you made. You said the alliances will not compete with each other. I am a consumer, and I am in alliance A, and I do not think they are doing a very good job; won't I be able to go to alliance B?

Ms. FEDER. Senator, the alliance is essentially giving you the choice of health plans, and what we think that you will be evaluating as a consumer is what kind of access you are getting to your doctor and whether you are happy with your doctor and whether your bills are paid. And that really is at the health plan level, and you will have choices of Plan A, Plan B, many plans.

The alliance is simply giving you the opportunity to evaluate and to choose from among those health plans.

Senator METZENBAUM. Yes, but that assumes that the alliance is run well. I have to assume the opposite, that some alliances will be taken over by the insurance industry, by the medical industry, by special interest groups, maybe by the corporate community. What concerns me is that I as a consumer, my voice will no longer be heard. If I had a choice between two or three different alliances, then at least the alliances are competing for my dollars, and then those alliances have to go out and make the best deal with health plan A, B, C, or D.

Ms. FEDER. Well, I think your concern about holding the alliances as well as the plans accountable to consumers is critical. But I am not sure that competition among alliances is the best way to do that.

I think to set up that system, as I indicated, would put all of us at risk, or put you at risk, of recreating some of the current conditions that we now face in which people with different health risks would be able to choose different alliances, and that might make matters worse.

It would seem to me that to address the very critical concerns that you raise, we need to address the accountability of the alliance to consumers in terms of the structure of its board, predictions against conflicts of interest on that board, in terms of a consumer ombudsman within the alliance to assist consumers who are having difficulty, and generally holding that alliance accountable to the standards and guarantees that are established at the Federal level.

Senator METZENBAUM. Dr. Feder, as sure as I am sitting here, some of those alliances will become monolithic, some of them will take unto themselves powers that are not pro-consumer. They will be thinking more about preserving their position, about whom they are doing business with and what is in it for them.

You envision a perfect society, but I recognize a very imperfect society, and I think that the total elimination of the competitive factor with respect to the alliances and only providing the competition between the various health plans is a disservice to the whole concept.

Let us assume that the alliance in my community or your community is not satisfactory. What choice do I then have, or do you have?

Ms. FEDER. Then, Senator, I think that that alliance that is not satisfactory needs to cease to exist; the State needs to establish a new one, and if you need some assistance from the Federal Government in that regard, that needs to be a part of the system.

I guess my concern, Senator, is not that I envision a perfect world or that we envision a perfect world; it is where there are imperfections, what are the best mechanisms to keep the system working. Again, it is our view that the competition among health plans makes sense. To allow the competition among alliances means that you will essentially have, I think, discrimination based on health status and other factors—precisely the circumstance I think we all want to avoid.

So if we need better accountability, that is where I think we ought to work.

Senator METZENBAUM. But you talk about accountability as if the State or the Federal Government would protect the average individual. State Governments do a lousy job—and I use the word “lousy” appropriately—as far as protecting people in buying insurance. There is no State insurance regulation that is worth a tinker’s dam, except in a few exceptional States.

Now you are assuming that the insurance department is going to sort of provide protection, you are assuming that the individual is going to have some access to his or her Federal Government and the protection. And I would just say to you that I think you are heading down a road that is truly retrogressive and unrealistic, and I think the American consumer is going to get the short end of that deal.

Ms. FEDER. Well, I guess I would say that we need to work harder on what it is that is of concern to you and to establish the accountability mechanisms that we think employers and consumers in a community, when given a structure for holding health insurance plans accountable to them, we think that they will want to take advantage of that and us that well if we have predictions in the system, and if the rules of the game are firmly and fairly established, which we think is a critical Federal role. We just need to keep working on it.

Senator METZENBAUM. All I can say is it is a very big “if,” a very big “if,” and I am very concerned.

The CHAIRMAN. Just for clarification, are you concerned that they would have one alliance in Concord, MA that may be very healthy, and a different one in Boston, where the expenses are higher, and therefore—

Ms. FEDER. What I hear suggested by the Senator, and it goes with voluntary alliances, is that Boston would have multiple alliances, and if Boston has multiple alliances, then it leaves businesses choosing which business to be in—I think we actually have some of that circumstance in Cleveland at the moment where there is a voluntary alliance, and it has been helpful to those small employers who are in it, in terms of getting good deals with respect to insurance companies, but it has not been able to address the problem of risk selection where, when a business has somebody who gets sick, that business tends to fall out of that operation, and then gets shunted off to some other entity. That I think is what the primary problem is in that regard.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. I want to shift to the other end of the scale here. As you know, I come from Vermont, and we have an authority that is set up, and I expect it will be some kind of a modified

single-payer system or some in-between system. First of all, when we deal with multi-State employers, as you know, presently, you can get a waiver for ERISA requirements in that regard. Your paper says you may. Are there going to be standards established for a State so that they will get it and know they will get it if they do certain things, or how are you going to handle that?

Ms. FEDER. The objective there specifically with respect to States that want to establish a single-payer system for all the State is to make virtually automatic an ERISA waiver and allow the integration of all businesses in the State into the system.

Senator JEFFORDS. Second, if we have a health authority now, which in a sense is an alliance, you prohibit as membership in the alliance, providers. If we have a system which is going to probably have even regulatory authority to set the payments to providers, could you get a waiver for having at least representatives of providers on that?

Ms. FEDER. I think our primary concern in terms of the make-up of an alliance—which actually may not apply in a single-payer State, and we would want to look at that carefully—but the concern about the make-up of an alliance is to avoid the kinds of conflicts of interest and takeovers that Senator Metzenbaum was alluding to and essentially to keep the alliance accountable and responsible to consumers and not have insurers or providers on that. That does not prohibit in certain circumstances having advisory bodies or other input. But it is particularly with respect to the selection of plans that is our concern, and it might be appropriate to have different arrangements in a single-payer system.

Senator JEFFORDS. Then, from a single-payer State's perspective, we should be careful to make sure that we would either be able to get a waiver, or that there would be some provision for the protection of the providers to ensure that the authority would not—I am sure they would not want to—but run the providers out of State. There is concern in Vermont about having some say on any board that is going to be setting their rates.

Ms. FEDER. Again, I think that subject to the concerns that I have indicated, we could look to that and see what the circumstances are.

Senator JEFFORDS. Second, you also prescribe the use of revenue sources for a State so that you cannot use the same revenue source as the Federal Government uses. Does that mean a State could not impose an additional payroll premium to assist in its system?

Ms. FEDER. That concern has been raised in discussions with Vermont and others, and it is my understanding that they would be interested in looking to the same source, but possibly in a different form, not looking at a premium source.

We have been taking their concerns under consideration, so that it may be that there is more accommodation there than we had indicated.

I think our concern is that we not have such differential finding across States. Differential systems makes a great deal of sense, but differential financing can create problems at borders as to in whose interest it is to locate where. So our objective here was to have a level playing field with respect to financing in that regard. That is why we set it up in that way.

Senator JEFFORDS. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Harkin.

Senator HARKIN. Thank you, Mr. Chairman.

Dr. Feder, I have been having a lot of town meetings and open forums in Iowa, going through this plan, the proposal. There have been a lot of good questions and a lot of good input from people in rural areas.

The President's proposal allows for the Medicare population to be folded into a regional alliance; they can be folded in or opt out, either on a personal basis, as I understand it—an individual can—or the State might be allowed to fold the entire Medicare population into the alliance. Is that correct?

Ms. FEDER. Yes. It might be helpful to clarify a little in that regard. In terms of the State opportunity to create a fully integrated system, that is something that would occur after alliances are fully up and running, so that is a somewhat later period, and would be subject to Federal approval that looks to guaranteeing the benefits for Medicare beneficiaries and fiscal predictions.

Senator HARKIN. For instance, take Iowa. Iowa is number one in our Nation in proportion to our population, in people over age 85. We are number three in the Nation in people over age 65, proportionately. And again, at these town meetings, providers have stressed to me the importance of including Medicare.

For example, many of our hospitals in rural Iowa, their patient load is 70 percent Medicare. If they are not in the alliance, then obviously the cost to everyone else in that area is going to skyrocket, if they are out of the alliance. And they are concerned about leaving this up to the States to decide. Many of them would like to have this done at the Federal level and just fold Medicare right into the alliances.

And I must tell you that when I question people who are on Medicare in Iowa about this, I find at least an even split, and even more perhaps are thinking they would rather be in the alliance than have Medicare separately. They have had a lot of problems with Medicare, a lot of paperwork, a lot of procedures that have not been reimbursed fully, and I think there are a lot of Medicare recipients in Iowa who feel like they would like to be a part of the overall alliance.

So again, why not just fold the whole thing in at the beginning?

Ms. FEDER. As we have looked at that, what we have tried to do is enable seniors to be able to take advantage of the new system and enable providers to organize plans that can serve seniors and the younger population at the same time.

We have tried to balance the desire to move toward a single system for all with some concerns about how rapidly we can do that with respect to the older population. So let me indicate the way we think we are doing that.

Individual seniors will indeed, as you recognized, have access to the alliance system and the alliance plan. They have the opportunity to choose to stay in the alliance at age 65. Older seniors will increasingly have opportunities to enroll in plans that are in the alliance, with Medicare making payments on their behalf.

So we think that we are creating a system in which, at the most important level, the delivery system level, that kind of integration of everyone into the same system is occurring.

On the other side, there are differences currently between the Medicare benefit package—there are some differences there. There are differences in the way Medicare pays providers. There is an existing system, and to meld that full, broad, older population into a newly emerging system might indeed endanger both the new system and the predictions for seniors. So we are looking for some time as a way to proceed now.

Senator HARKIN. On the other hand, in a rural area in Iowa, if you have this opt-out, and if there is a separate Medicare system in the alliances, I do not know how they are going to operate. And that is the second part of my question. In rural areas in Iowa, they are concerned about how the alliances are going to serve them, and I have been asked some pretty tough questions for which I had no answer. They are concerned that plans will not be developed in rural areas, and how are the alliances going to ensure that people who live in widely disbursed small towns and communities in rural areas are going to be served by a plan. I do not understand that.

Ms. FEDER. Yes. Well, we certainly do not want to leave you with no answers, and we need to share with you the work that we did in the course of the working groups, in terms of enabling rural areas to have better access than they do today. It has to do with the scope of the alliance; if the population is very dispersed, you might want to cover a very large area in a single alliance. Essentially, it is the job of the State to make sure that there is a plan everywhere. Most importantly, that means making certain that there are providers everywhere and making certain that we have practitioners there.

Senator HARKIN. How do you do that? I know there are some incentives built into the tax credits, the \$1,000 a month and so on, but I am not certain that that does it.

Ms. FEDER. Well, I think we need all of those things, and you are right, it is a challenge; we need to do all of those things. I think we also need to create connections for providers who are in rural areas with the services and expertise and backup that is in the more densely populated areas, and we have explicit mechanisms for creating those connections.

Senator HARKIN. The plans are supposed to compete and thus hold down prices; right? The plans compete.

Ms. FEDER. That is part of the system, but that may not work in a rural area.

Senator HARKIN. That is the question. How do you hold that down in rural areas?

Ms. FEDER. Sometimes when we use labels, we get into ideological issues here, and we do not believe there is a one-size-fits-all system for the country or even within States. So the goal in the rural area, as I said, is to make sure the services are there where they are often now lacking.

One of the best ways to hold down costs in that area is to get at what some have called some "managed cooperation" and get rid of some of the inefficiencies in terms of duplication of service.

Senator HARKIN. My time is up. Do I have time for one more?

Senator Kassebaum [presiding]. Well, I think Senator Wofford is trying to ask some questions before he votes.

Senator WOFFORD. If I could just ask one before we run.

Senator HARKIN. OK.

Senator WOFFORD. I am very interested in this question. I take it a State might choose to have one alliance for all rural areas?

Ms. FEDER. Absolutely, it may.

Senator WOFFORD. How about metropolitan areas with three States?

Ms. FEDER. There is certainly the capacity and the opportunity to create a cooperative alliance. It is not required.

Senator WOFFORD. In Philadelphia, or even the District of Columbia, as an example, where people are living in one of three States and working in the District of Columbia.

Ms. FEDER. The plans go across geographic areas. The challenge that we face here is that when relying on a State-run system, if you go across State boundaries, then we are relying on cooperation as opposed to a requirement that an alliance cross those boundaries.

Senator WOFFORD. Just one other analogy. Am I right in thinking that from the consumer point of view, in terms of the choice and how it would operate, it is not very different in choosing from your menu, or in your supermarket, from the kinds of choices that millions of Federal employees have now—the State of Pennsylvania employees and the State of California public employees—in which each year, they have that kind of menu, and they are given that choice; is that a good analogy?

Ms. FEDER. It is similar, only again I would say better in that there is a common guaranteed benefit package that makes it easier for people to choose.

Senator WOFFORD. And the organization of the alliance is not your employer—in each of my cases, it is your employer—but it is a consumer-driven structure.

Ms. FEDER. That is right, which makes it easier, we would say, for consumers and employers alike.

Senator WOFFORD. Are you going to require that the alliances be nonprofit corporations and not Government entities?

Ms. FEDER. That is something we have under review, and we feel it is increasingly important to emphasize that they be consumer-driven.

Senator WOFFORD. I am very interested in their not being Government entities, but being nonprofit corporations run by consumers.

Thank you.

Ms. FEDER. Thank you, Senator.

Senator KASSEBAUM. Dr. Feder, I am very sorry. There is a vote on, and it was Senator Kennedy's intent to be back, but we may have to just recess for a few moments.

Ms. FEDER. That is fine.

Senator KASSEBAUM. The committee stands in recess.

[Recess.]

Senator Gregg [presiding]. If we could begin again, I am going to be allowed to be chairman for about 2 minutes, and I think I can straighten this all out. [Laughter.]

Ms. FEDER. I am happy to do it with you. Let us do it.

Senator GREGG. I guess my first comment would be that this analogy of the supermarket is an interesting one, and I found it a bit eye-opening that you feel that it works well, because of course, in Lowell, MA or in Nashua, NH, which happens to be right beside Lowell, a consumer can go to any supermarket he wants. He can go to Market Basket, he can go to Shaw's, he can go to Stop and Save; and if he does not like the supermarkets, he can go to the wholesale food stores, he can go to Sun Foods; and if he does not like those, he can drive into Boston and go to Haymarket and the farmer's market.

So the description of the supermarket being the only place in town where you can go is really move of a collectivist approach to supermarketing. You might say you only get one choice, one supermarket. And I think this follows up on Senator Metzenbaum's comments, that is to say, if you are really going to bring the consumer into the system, you have got to give him a few supermarkets to go to, not just one.

Ms. FEDER. Well, again, I would not call it "collectivist"; I would call it "wholesaling" here. Essentially, the question is whether we focus the competition on the markets or on the products. And again, as I indicated earlier, we think the competition belongs among the health plans. What we want is competition based on efficient delivery of quality care at affordable prices. That is the health plan competition.

Again, the concern and where I think the analogy does not work is with respect to what happens when you have all the segmentation into different markets. It is not that you would get all broad equivalent supermarkets. It is that you would get different alliances, different markets, in which the consumers were very different.

The concern would be that every market would have an incentive to get rid of its people when they get sick, just the way they do now, and that essentially you would have selection by employers. You would have those who are young and healthy in one; when they are working age, they would end up in another; when people get sick, they would have difficulty staying in an alliance. You would get the fragmentation and falling apart of a system just the way you have it today.

So what we think we need is a common pool where we cannot have that kind of cherry-picking and fragmentation.

Senator GREGG. You might even get all the smokers in one and all the healthy people who do not smoke in another one, paying different rates; right?

Ms. FEDER. Well, I do not think this happens on behavior. Essentially, what you get is older people in trouble, and you get people with cancer in trouble. That is the kind of trouble you face.

Senator GREGG. You represent this is not a regulatory body, but as I read page 61 of the publication by the Bureau of National Affairs, Inc.—I do not know if that is the official publication or not—but anyway, it says under "Alliance powers," that "a provider may not charge or collect from a patient a fee in excess of the fee schedule adopted by the alliance."

Now, that is price controls; that is the ultimate regulatory exercise to set a fee schedule and State that you cannot adopt anything but that fee schedule. That is regulation—that is more than regulation, but I mean at a threshold, at least, it is regulation.

Ms. FEDER. It is a formal payment arrangement that we see as negotiated between the alliances and the providers, and we specify that.

Senator GREGG. It says “adopted by.”

Ms. FEDER. Well, I believe it says elsewhere that it is negotiated, but if not, then we need to clarify that.

I think that the goal here, again, is security and certainty for consumers. When we have established the characteristics of health plans, we have indicated the kinds of cost-sharing and the differences in cost-sharing across plans.

If doctors can charge above plan rates, can “balance bill,” as it were, consumers are at risk for substantially more than the cost-sharing that is specified in the plan. That is a real problem in terms of financial security, and it is that problem we are trying to address.

Senator GREGG. But you are addressing it through the most onerous form of regulation, price controls.

Ms. FEDER. Essentially, I think the issue is, as I said, it is a negotiated rate schedule. Essentially, the rates have to be clear as to what is being paid and charged in a community.

Senator GREGG. Yes, but don't you have global budgeting in this? Isn't there a budget set here that is referred back to the National Health Board. According to this flow chart here, at least, that is what happens.

Ms. FEDER. What there is is a constraint on premiums.

Senator GREGG. Right. OK. “Constraint on premiums” is the new euphemism for price controls. Fine. But it is price controls.

Ms. FEDER. It is a clarification of how it works.

Senator GREGG. A clarification. I remember “revenue enhancement,” which was a clarification of “tax increases.”

If you are going to do this sort of clarification, why not go directly to wage controls? Why stop here?

Ms. FEDER. The reason that I clarified was to indicate why it is that we are not relying on price regulation of provider payment. We are looking at limits on premiums, and we think that is a very different approach. We also think it is a backstop mechanism, that it is competition that will keep premiums in line, but we have the backstop mechanism, and the difference between that and a provider price regulatory approach is that it gives an insurance plan, a health plan, flexibility to determine its payment rates to providers.

The fee schedule you talked about applies only to fee-for-service components of plans. Plans that form networks essentially determine their own terms of payment, and will be able to establish mechanisms that address not only appropriate payment for services, but appropriate use of services, and that is what we think that relying on premium constraints accomplishes.

Senator GREGG. My time has expired, but I would like to submit some questions in writing to follow up on that issue.

Thank you.

[Answers to questions of Senator Gregg are retained in the files of the committee.]

The CHAIRMAN. Senator Mikulski.

Senator MIKULSKI. Thank you very much, Mr. Chairman.

Dr. Feder, I just want to thank you for all the work that you have put into establishing this framework for national health insurance reform.

Ms. FEDER. Thank you, Senator.

Senator MIKULSKI. As we move ahead now to really focusing on bills and legislation, know that I have some apprehensions about the concept of the health alliance, and they fall in two categories. One, what happens to the concept of being mission-driven as compared to market-driven, and then just pure bureaucracy.

My concern as we try to get costs under control and bring marketplace disciplines into the system through the health alliance, which is probably the most important organizational mechanism for this, that there will be such emphasis on marketplace, such emphasis on competition, such emphasis on cost, that those providers that are mission-driven will suffer in the process.

I think in terms of my own home town, of three institutions—Johns Hopkins, Mercy Hospital, and Sinai—Mercy and Sinai are community-based hospitals that work cooperatively on medical education, but they serve the poor, they serve new immigrant populations, and they are in neighborhoods where they must spend a preponderant amount on security. They are not out to guild their stethoscope or guild their MRI, even if they have one.

I am concerned that we could come out with a health alliance that essentially has a discount store mentality to health insurance. Quite frankly, I am concerned about that. And then you have the high-tech, high research educational facility.

Could you comment as to what is in the legislative proposal that will ensure that health alliances will also have a sense of mission-driven, because I do not believe that health care is a business like any other business. It is not like Nick's Diner or Yellow Freight Transport Company.

Ms. FEDER. I think that those mission-driven institutions are likely to have an enhanced capacity to operate effectively under this system, for a couple of critical reasons.

One is that right now, they are the ones who are serving people who have no capacity to pay. I mean, essentially, they are stuck. And what the new system will do is guarantee that everyone who comes through that door is carrying payment with them that enables those institutions to operate effectively and provide high-quality care.

Those resources, in addition to supports that are part of our reform plan, will enable those institutions to form networks and plans in their communities, so that they who have been the traditional providers to that community have the continued capacity and in fact enhanced capacity to serve those disadvantaged populations and not be disadvantaged in the process.

So we share your concern, and we are looking for ways to strengthen the availability of dedicated providers to their communities.

Senator MIKULSKI. Well, I understand how they could benefit under the universal access and dealing with the uncompensated care. But as I understand it, they will decide which health plans will be part of the alliance.

Ms. FEDER. No. Alliances do not decide who gets to be in. Any health plan that meets the qualifications—again, with some constraint on the level of their premium and enforcement of their contracts—is accepted by the alliance. So there is no opportunity to exclude at all in this regard.

There is another factor, Senator, that I should have mentioned, which is we have also to deal with the extra costs that the providers you are talking about face in terms of dealing with low-income populations, and security, and so on.

Senator MIKULSKI. Or complex populations, like Soviet Jews coming into this country.

Ms. FEDER. Exactly; an array of social difficulties. We have included risk adjustment factors which enable plans in that area, without charging more to their consumers, to get more revenues in to address those problems. So we have explicitly addressed that problem along with, for Hopkins or institutions like it, addressing separately, outside the premium process, the extra costs that go with academic health centers.

Senator MIKULSKI. I have another question just about the sheer size of the bureaucracy. As a populist, I am always wary of bureaucracies, and particularly State or governmental bureaucracies.

What would be your answer to those who say that this is just too big, too complicated, it is going to be too bureaucratic, and is just going to sop up a lot of money, have excessive control, and that ultimately, it will be the heavy hand of Government intruding both in the marketplace and within mission-driven agencies?

Ms. FEDER. I would say that what we are doing is replacing the inept, wasteful, and ineffective bureaucracy, if you will, of the unfettered marketplace, and that we need to bring together in an organization that is run by consumers a much more efficient operation that will be accountable to them.

Senator MIKULSKI. Thank you, Mr. Chairman.

I see that you are "Feder-izing" the marketplace.

Senator WELLSTONE. I was going to say, is that "un-Federed" with a "d"? [Laughter.]

Ms. T4Feder. With two t's.

The CHAIRMAN. I would just mention you might check with the neighborhood health centers. I know they have met with Phil Lee up in Massachusetts, and they are not quite as sanguine about the total reimbursements and the drain that they would have. They have primary care physicians now, and there will be a premium on primary care. They have gone a long way in order to be able to get them, and they are concerned that they might lose them. I know you have taken the time to talk to a lot of people, but perhaps you might talk with Dr. Lee about some of the concerns that they have mentioned.

Ms. FEDER. We do talk regularly, and whatever it takes, Senator.

The CHAIRMAN. Thank you.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Judy, I echo what Barbara said; we all compliment you for your commitment, and those of us who have known you for a long time really mean that when we say it.

Ms. FEDER. Thank you, Senator.

Senator DURENBERGER. And you know that since we have known each other and dealt with these issues, we have often disagreed, but we have always consulted, and we have always respected each other, and I want to reiterate that in a public way.

Ms. FEDER. Thank you, Senator.

Senator DURENBERGER. Second, I would appreciate it very much if someone would print up Senator Mikulski's question and you would give us a written response to that because that is a very important question. I think you need time to respond, and we all need a very clear response to that question, because you are hearing it in Maryland, you are hearing it in Minnesota—

Ms. FEDER. Absolutely.

Senator MIKULSKI. Are you talking about the mission-driven aspect, Senator?

Senator DURENBERGER. Yes—your last question relative to the federalizing or the “governmentizing” of these supposedly member-owned organizations.

Next, just a quick observation to get to some questions. As sort of an original Jackson Holer, I think I can say something about the purposes of the health alliance, and that is that the alliance as such is necessary to make individual choice and consumer choice effective in changing markets. Right now, we have splintered markets; everybody makes their own choices, and we are all at the mercy of the sales operation, which does not really have to stand behind the product, if you will. So it is necessary to make individual choice work. But the alliance does not make it happen. What makes it happen is the accountable health plan. And I hope when we get to that hearing in this committee, we will pay an awful lot of attention to what we can already see in the marketplace, namely people in a very dysfunctional market trying to be accountable.

But the critical thing here is that health alliances are not going to change the system. They are going to bring a lot of people together, but it is the accountable health plan, that gets to the consumer, that actually changes the system, produces information, services the customers, stands behind the product, and takes responsibility in a competitive market for what they do.

That leads me to another question that Senator Mikulski asked you. I heard you say that any plan in a community must be presented to the members of a health alliance. Does that mean any plan that complies with a certain set of national rules?

Ms. FEDER. Absolutely. Any plan certified as in compliance with those rules.

Senator DURENBERGER. Does the administration have a consensus yet, or is that developing, on what those national rules ought to be so that we would know what is a health plan and what is not?

Ms. FEDER. What is a certified plan, yes. I think actually, we have been relatively clear in specifying those conditions. It has to do with offering the guaranteed package. It has to do with participating in the quality improvement system.

Senator DURENBERGER. Is there a written——

Ms. FEDER. Yes, sir——

Senator DURENBERGER. I mean, if we were going to legislate rules for accountable health plans, is that all written down someplace?

Ms. FEDER. Yes.

Senator DURENBERGER. OK. How about what a health alliance is? Has that all been produced in legislative language, and will we see it when the time comes?

Ms. FEDER. You will see that, yes.

Senator DURENBERGER. But the exception to that is people who charge too much for their plans.

Ms. FEDER. We have stated that the alliance need not accept plans whose bids exceed 120 percent of the average.

Senator DURENBERGER. And why would you do that? I mean, if this is a consumer-driven process, why would you exclude people who charge too much? Why not just let the market decide?

Ms. FEDER. It is possible to go that way. I think our concern is that we have a system; we know that we are seeking to achieve certain goals in terms of slowdown in expenditure rates. We do have the competitive system on which we are heavily banking. We think that setting the ceiling that high, based on information that we have seen, excludes almost no one, but essentially, we think it provides some kind of overall safety net.

Senator DURENBERGER. Do the large employer purchasers who are outside the health alliance have to live by the same rules?

Ms. FEDER. Yes, sir.

Senator DURENBERGER. So they have to present all accountable plans in the community?

Ms. FEDER. Not all. Excuse me, I overstated. They have to live by many of the same rules. They have to guarantee their employees a choice of plans. They must guarantee them the benefit package and the availability of that package, regardless of risk.

So in terms of the consumer choice and predictions, those are the conditions that they must comply with.

Senator DURENBERGER. If I understand the proposal correctly on the health alliance, the alliance collects premiums from its members?

Ms. FEDER. That is correct.

Senator DURENBERGER. How do you collect premiums from people who have no health plan when they show up in the hospital?

Ms. FEDER. Essentially what we have said is that they are guaranteed coverage. They sign up afterward. The alliance identifies them by virtue of their having shown up for service, and then it becomes——

Senator DURENBERGER. Suppose it is a homeless person on the street who gets run over. How do you collect premiums from that person afterward?

Ms. FEDER. Well, in your particular example, I do not know that investing a good deal of effort would be—if they have resources, you go after them; if they do not, you do not. Essentially, the particular case you put forward, there may not be resources to collect, and that would be a subsidized individual. Essentially, someone

else shows up, and the alliance then, like any business collecting on its bills, would collect.

Senator DURENBERGER. But I am assuming that eventually we are going to have a plan that is fully federally funded for up to 100 percent of poverty, so there is a process to pay for the homeless person.

Ms. FEDER. Subsidies.

Senator DURENBERGER. How about the independent contractor, the small businessperson, who does pay taxes and is at three or four times the poverty rate; how are you going to collect from those people?

Ms. FEDER. Again, the alliance sets up a system for collecting from the businesses, and essentially, we would expect it to be similar to many private operations in bill collection efforts. That is the way in which it would operate.

Senator DURENBERGER. The phrase, "health planning authority," of regional alliances appears somewhere in the administration's proposal. Is that true?

Ms. FEDER. Well, it is not ringing a bell for us, but go ahead.

Senator DURENBERGER. Well, if it does not—my time has expired—I have got it wrong. You are not contemplating health planning authority in the health alliances?

Ms. FEDER. No, sir. It is not—no.

Senator DURENBERGER. Thank you, Mr. Chairman.

The CHAIRMAN. We have Ms. Feder just until 11:20, so maybe we could each ask two questions or so, if we could.

Senator Wellstone.

Senator WELLSTONE. First of all, real quickly, in response to Senator Durenberger's question about the 120 percent rule, you said that would be open. I have to tell you that, from the point of view of some of us, there would be enormous opposition if you do not keep that, because the choice will be for people with high, high incomes to buy up, up, up, and you are going to have the same stratification that I presume we want to avoid, which is one of the reasons I still think we all ought to agree to participate in the average price plan, and I will come back to that on the floor of the Senate.

I want to ask you a question that I think is very critical to trying to build a broad base of support. That has to do with the whole issue of a level playing field—you used that language—and States in fact being able to design their own plans, and maybe it is a single-payer plan.

Now, I understand what you were talking about when you mentioned level playing field in relation to a payroll tax, but above and beyond that, there is a question of waivers. Let me just read what I have seen in writing. The waiver for single-payer requires "rules on participation in corporate and regional alliances."

Now, why would people who want to go single-payer have to jump through hoop? That is the kind of thing that makes us think that in fact you are not going to have a level playing field.

Ms. FEDER. Let me clarify. As you know, part of the reason for sharing that information with you earlier was to get your responses, because our intent is—

Senator WELLSTONE. Now you have our response.

Ms. FEDER [continuing.] —now we have your responses—our intent is not to have a series of hoops. That is an option that States, is to have a single-payer system. It does require certain waivers, and we are looking at facilitating those waiver processes because it really is our intent to allow the flexibility you seem to be seeking.

Senator WELLSTONE. One thing I would suggest is that there is a real concern about these waivers, and unless we get that cleared up, and some of the restrictions on financing and some of the level playing field issues in relation to Federal Government vis-a-vis subsidies for States that go in this direction, we are still not really going to have a level playing field. I think that is something that we are going to have to work on very hard before there is going to be support from people who feel very strongly about this.

I think it is in the best tradition of this country, in fact. We are a grassroots political culture. We say States are laboratories of reform. Let us allow it to be an equal playing field, and 5 years from now, let us take a look at who is able to deal with skyrocketing costs and provide the coverage and so on and so forth. That is my first point.

Ms. FEDER. I think we share your point of view in terms of flexibility.

Senator WELLSTONE. OK. I am glad to hear that, but we are going to have to have it in writing, and I want to emphasize that with you.

Second of all—and I should have thanked you first of all for all your work. Let me have a mood change and say thank you for all your work.

Ms. FEDER. You are welcome.

Senator WELLSTONE. I am sorry. You know, you really get into this stuff, right?

The second thing is in relation to this opt-out, if companies of 5,000 employees and over nationally can opt out, I first of all have concern about cost-shifting within the States vis-a-vis those opt-out plans and the alliance plans, or alliances' plans. But second, I have concerns about the same problem of risk selection. How do you know a company is not hiring you because your daughter has diabetes, or is letting you go because one of your children is sick? Who is going to regulate that.

Now let me go further, because you said the alliances are not going to be doing any regulation. There is unfortunately a lot of evidence—we just had a situation in Minnesota which was dramatic news, where Ramsey County, the largest medical society, said they wanted a study of single-payer. Then the State AMA met, the delegates, and by an 86-82 vote—that is a pretty narrow margin—or 86-80, split in half over whether the State should study single-payer.

Why? Some managed care is fine, other managed care plans are not so fine. They micromanage the caregivers, and in addition, in terms of where they locate, in terms of their marketing strategies, in terms of how some of the people that Senator Mikulski was talking about are dealt with or not dealt with. There is all sorts of potential, given this incentive to compete on the basis of keeping costs down, for abuse.

Where does that get dealt with if we are going to talk about protection for consumers?

Ms. FEDER. All right. On the first point about the cost-shift in terms of allowing people—

Senator WELLSTONE. That is the least important part, but go ahead.

Ms. FEDER. Well, essentially, I guess I would want to say that all plans are held accountable for delivering the guaranteed package subject to the premium constraints, and that applies to the corporate alliances as well as to the plans in the health alliances. So I think that that is dealt with.

Senator WELLSTONE. Well, the same package of benefits, but what about—

Ms. FEDER. The same package, and the premium constraint applies to all. The safety net premium constraint applies to all.

Senator WELLSTONE. OK.

Ms. FEDER. And in terms of discrimination, corporate plans must cover all their workers, and I think that there is certainly no worsening of hiring discrimination.

Senator WELLSTONE. Who assures that?

Ms. FEDER. The ultimate assurance is the Department of Labor, essentially, that we are relying on.

Senator WELLSTONE. Can I interrupt you with just one point, and then I promise it is your turn.

Ms. FEDER. Certainly.

Senator WELLSTONE. One of the questions I have is that I think that given the incentives that are built into this competing on the basis of keeping costs down, given the news that we see about the mergers that are taking place—what is it, 40 percent of managed care networks are now owned by the insurance industry? I think that is what I just read, and now we see that this is the market that is being eyed by the big insurance companies. There was an article the other day, talking about Humana moving in.

It strikes me that you are going to have all sorts of potential problems vis-a-vis some of these abuses, and you are going to have to create a bureaucracy to regulate these abuses, which is the very bureaucracy we are supposed to be trying to eliminate to reduce costs.

Ms. FEDER. I answered the question because you raised it with respect to the corporate alliances, and we do know that right now, there are no regulation on self-insured, or effective regulation of self-insured plans. All I was indicating was that those would be in place under the system.

Senator WELLSTONE. Which?

Ms. FEDER. The regulating of the self-insured plans that does not exist today. It is a minority of businesses, a small minority, that are outside the alliances, but one does need to have a guarantee there as well, that does not exist today.

Senator WELLSTONE. OK. The guarantee will be there.

Ms. FEDER. The guarantee must be there, because it is not an opt-out; it is a different way to achieve the national guarantees, and they must be achieved.

With respect to the competition in the system and your concerns, I think there are a lot of concerns, and a lot of people have those

concerns, and the competition that is going on in the marketplace today raises a lot of those concerns. But the system right now does not create an opportunity in which we can hold plans accountable, and that is what we have to change. We have to have a guaranteed benefit package, we have to have a data system that lets us know what kind of quality is there. We have to have information what is going on in the plan, the publication of their utilization control strategies.

We will have a new incentive that does not now exist today for doctors and hospitals themselves to essentially put themselves in the driver's seat with respect to those plans. And we would argue that with the guarantees in terms of quality and information and guaranteed benefits, that we can allow and benefit from the price competition.

Senator WELLSTONE. Thank you, and I will go back to Senator Metzenbaum's point in 10 seconds, which is that I think in Minnesota—I may be a little off—there is now one person in the department of commerce to regulate something like 900 insurance companies with 5,000 different plans. I have to tell you I do not quite see where this consumer accountability, consumer protection, consumer input and consumer voice fits into this yet.

I know what you are saying in your words, but I do not see how it works. I know you are committed to it, which is what makes me feel good about it. Enough said.

Ms. FEDER. But the commitment needs to be realized, so we will keep working on it.

Senator WELLSTONE. OK. Sounds good.

The CHAIRMAN. Senator Coats.

Senator COATS. I apologize for plowing old ground here, but I want to follow up on Senator Metzenbaum's point, and I missed some of what went on after that because I had two appointments I had to take care of, so maybe it was already covered, but just for my own edification.

Let me see if I can put this in more easily comprehensible terms, at least to me. Let us assume that the District of Columbia sets up one alliance for the District of Columbia. Let us assume that the State of Virginia sets up two; they separate Northern Virginia from the rest of the State, and they have two alliances.

Now, if I am a resident of the District of Columbia, I have to join the District of Columbia alliance. I cannot belong to another alliance. Is that right?

Ms. FEDER. That is correct.

Senator COATS. Well, in response to Senator Kennedy's question, you talked about we are going to put information—it is like a list, and we are going to label how well or how not well the various plans are within the alliance. But what if I do not like the alliance itself—because we are going to limit the total budget of that alliance, right? I mean, they have to deliver care for everybody in the alliance within a certain budget.

Ms. FEDER. The premiums in the alliance are what are constrained—of the plans. It is not the alliance; it is the average premium of the plans in the alliance.

Senator COATS. But those premiums can only go up a certain amount.

Ms. FEDER. That is right.

Senator COATS. So what if I am living in the District of Columbia, and because the premiums are limited, the District of Columbia alliance says, "We cannot make it under this premium cap because our experience here, given the crime and the amount of violence that occurs"—as compared to, say, the Virginia alliance, or the choices that people have made here in the District are different from there—I am locked into the District of Columbia alliance. I cannot go across the river. Is that right?

Ms. FEDER. What I think you are talking about here is your health plan. And the plans may indeed cross boundaries as they do today. There is no reason to think they would not.

Senator COATS. Yes, but I have to select plans that are within what has been approved by the alliance.

Ms. FEDER. Plans that are offered by the alliance; that is correct.

Senator COATS. What if I do not like the way the alliance is being run? What if I think they are mismanaging, or I do not like the plans they have selected or the way they have selected their plans—or, in order to meet their budget, they have had to select plans that provide a limited health care option as compared to, say, what I could get across the river?

Ms. FEDER. Well, I guess what I think is, in terms of what we have said about alliances making markets rather than regulating plans, that I do not know that that particular circumstance you are describing arises, because what matters is what plans develop in the District. And as I indicated, there is no reason to think the plans will not, as they do today, cross borders.

Senator COATS. But the alliance approves the plans. What if the alliance does not approve a package of plans that I like?

Ms. FEDER. This is a question that has to do with the Government, in terms of certifying the plans.

Senator COATS. Yes, that is the question.

Ms. FEDER. Well, but it is not an alliance function. That is a Government function. It is a question of certifying plans based on very clear-cut rules—the offering of the guaranteed benefit package, essentially the solvency of a plan, the capacity to provide the services are delivered, so that—

Senator COATS. But Senator Metzenbaum's question is a valid one because it basically says, okay, you are talking about competition among plans within the alliance, but what about competition between the alliances? Who is going to put the competitive pressure on the alliance to be competitive, or to offer programs that people are going to want to sign up for?

Ms. FEDER. Again, Senator, I think there is every reason to be concerned about holding alliances accountable to the consumers who run them, but it is not clear to me that competition is the way to achieve that. And I think if you think about competing alliances in the case of a large city, you create the problem that under the guise of competition, you have an alliance in a wealthy area of a community that is distinct from an alliance in a low-income area, and that that, under the guise of competition, really becomes a kind of discrimination.

Senator COATS. Yes, but it ignores the realities of differences in the way people pursue life styles and take care of themselves in different regions of the country, doesn't it?

Ms. FEDER. Well, I think what you were addressing was a concern about accountability, not a selection among people.

Senator COATS. But you just talked about selection.

Ms. FEDER. That is right, but I think that that selection, as we know from extensive experience in the current, is not about life styles; the selection is separating the sick from the healthy.

Senator COATS. It is analogous, I guess, to Senator Kennedy's illustration. If there is only one supermarket in town, there is no pressure on that supermarket—

Ms. FEDER. Yes, but there are a lot of cans of orange juice in that supermarket.

Senator COATS. But if only one person is purchasing those cans, they make the determination as to what choices. Let us say that in order to keep the premium cap increase costs, the store manager says, "We are going to go to Grade C meat, folks. That is just the way it is. It is the only way we can meet our budget."

And I say, look, I do not want to just have that choice. But I have nowhere else to go, right?

Ms. FEDER. Yes, and I guess—

Senator DURENBERGER. Dan, would you yield for a related question?

Senator COATS. Yes, I will be happy to yield.

Senator DURENBERGER. I think we are now on the track of a very important question. If I follow his question, if we live in the District of Columbia, we have only so many dollars to spend, either under a premium cap approach, a budget approach or similar. And even though you had accountable health plan competition, at some point, if the people here are sicker, and the cost of meeting the needs of this particular population keeps bumping up against that cap, the quality, whether it is Grade B or Grade C, is going to give. It is either going to be rationing or quality or something, isn't it?

Ms. FEDER. I think we have some projections in that regard. First of all, the costs of that system of services in the District to some high-risk populations are already in the services of providers here, and we are now and will continue, I would argue, to use those services and those providers because we value them—besides which they will have an opportunity to be more efficient under the new system and the new rules.

The second thing is I think to the extent that a population is more costly, or income is lower in an area, we have a Federal subsidy pool to protect the purchasers in that area and to cushion the obligations that are specific to an area. I think that is another very important component.

Senator DURENBERGER. Well, this is not the health alliance question as much as it is the dollar limit question. And the fear—the concern—that is being expressed here is that we do not want another situation where some people are moving out of the District to Virginia because they know they can get better health care in Virginia, because the only way you can buy it here is through this price-limited system.

Ms. FEDER. Absolutely. Senator, when you talk about bumping up the constraints, the way in which premiums are determined and the premium cap is a reflection of costs in an area. It is not imposed independent of the area costs, and so it is essentially reflecting the service costs in a community.

So the cap is consistent with area costs. You are not going to hit it sooner.

Senator COATS. Well, consistent with District of Columbia costs, but not—I mean, we have a not atypical situation here. There are a lot of regions of the country that merged, and metropolitan areas and State lines come together, and so forth, and so people's neighbors are going to be under an entirely different system than they are under, but yet there is really going to be no choice that individuals have among the systems. And I am afraid that what Senator Durenberger suggested is what is going to happen, that people are going to make the choice in terms of where they live.

Ms. FEDER. Well, I think we have variation in the costs in today's system, and although there are those who would move very rapidly to equalize costs everywhere, and we are concerned about that, or to eliminate unnecessary variations in costs. There will always be variations with cost of living and with other circumstances across areas. That is something we face today.

I think that the efficiencies we are putting into the system will dramatically reduce the variation that exists today, not exacerbate those difficulties.

Senator COATS. Well, I just want to go on record as sharing Senator Metzenbaum's real concern. I do not know of a model where you have one entity providing the services that does not become monopolistic—except the Soviet Union, and their grocery stores really did not carry that much stuff on the shelves.

Ms. FEDER. Well, let me say that that is not our model, to be clear, and to be very clear that, again, the alliance is not providing services; it is creating a market in which plans can provide services. We see competing plans in the District today, and there is no reason why we will not see them in the future.

Senator COATS. But there are real life restrictions on the market that that alliance can create, based on the premium caps. They are limited, and that is going to be driven by the geographic area and the health profile of the area where the lines are drawn. The people who draw those lines are going to be powerful people.

Senator DURENBERGER. Mr. Chairman, could I ask one related question, and that is what happens to the Federal Employees Health Benefit Plan, which is in effect, for this community at least, a health alliance already. It is the way in which a million—I do not know what the numbers are—

The CHAIRMAN. Nine million nationwide.

Senator DURENBERGER. Nine million. That is a lot of people. I mean, if this health alliance acted like the health alliances you would like to see, I am guessing we could change the market here rapidly. We could get a lot of things happening if just we, as buyers, performed the way I think you want health alliances to perform, that is, bring in accountable health plans, not the kind of insurance companies we have in this community now.

Ms. FEDER. What you are saying is—I think the Federal employee plan could create a better market than it does. I think our view is that essentially, we can do that best if everybody, Federal employees and everyone else in a community, is in the same competitive marketplace, all working effectively.

The CHAIRMAN. I have just two quick questions, and I know you have to go. If the insurance companies are not required to go through the alliances, as has been suggested, which is really what a voluntary alliance means, what protections do consumers have against excessive prices, poor services, pre-existing conditions, and isn't that essentially the current system?

Ms. FEDER. That would be our concern, Senator, that essentially you would be replicating the existing system.

The CHAIRMAN. And if you tried to police these things at the level of individual insurance companies, wouldn't you need a massive regulatory system?

Ms. FEDER. Absolutely.

Senator COATS. Well, again, Mr. Chairman, if I could just add something here.

The CHAIRMAN. Yes.

Senator COATS. The question—and I am not endorsing alliances—but the question is not a question of an alliance versus the present system. My question was why don't you at least let the alliances compete? I mean, wouldn't that hold down costs?

Ms. FEDER. I think that the chairman's concern is that if you have set up voluntary alliances, that you essentially have a picking apart of what we mean to be a community risk pool. And it is precisely that kind of picking apart that we are trying to solve.

Senator MIKULSKI. Does that mean cherry-picking, Dr. Feder?

Ms. FEDER. Yes, ma'am.

Senator MIKULSKI. In other words, that it would go to the suburban, with the occasionally sick and with mental health benefits for the worried well?

Ms. FEDER. The concern would be that if you do not have the community in one alliance, that you would have—

Senator MIKULSKI. You would leave out the homeless, for example, that Senator Durenberger mentioned?

Ms. FEDER. That is right.

Senator MIKULSKI. Thank you.

The CHAIRMAN. Just one other area, if you could. In my State, a lot of people who live on Cape Cod or in western Massachusetts travel to see specialists in Boston. Will they still have access to those specialists?

Ms. FEDER. Yes, sir. Essentially, if you are in a point-of-service or fee-for-service plan, you can go to any provider.

The CHAIRMAN. And finally, regarding people who live in one State—for example, people who work in Boston or Lawrence and live in New Hampshire, or work in Providence and live in Fall River or Attleboro—how would they be insured?

Ms. FEDER. Again, as Senator Durenberger indicated here, the key issue is the health plan, and health plans today are serving several residential areas in order to be able to serve people whether they are at home or at work. And we would expect the same to continue.

The CHAIRMAN. So, for example, we have people who retire and spend some time in the State and go down south in the colder season; with the current insurance programs, if they have medical needs, they are able to take advantage of services in those areas, and then the alliance would reimburse the system in another part of the country. Is that correct?

Ms. FEDER. That is right.

The CHAIRMAN. OK.

Senator DURENBERGER. Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Just one last comment rather than a question, Judy.

The CHAIRMAN. We do not want you to leave, Judy.

Senator DURENBERGER. That is true.

I just have to leave you with an instinct, or more than an instinct, I think, about the Federal Employee Health Benefit Plan. When I look at—and I have been doing this for many, many years, as you know—as I look at this, one of the weaknesses in the administration's plan is that there are a lot of political compromises. I somehow sense that there is a compromise here, having dealt with the Federal Employee Health Benefit Plan for a longtime, and having dealt with all of the union-sponsored plans and all the rest of it, that there may be some kind of a political compromise here that says we do not want to take on the Federal Employee Health Benefit Plan. But if in effect you are the President, and we are the Government, and we are the employers of all these people, there is an incredibly unique challenge before us right now to show everybody who lives in this town how competition actually could work.

What happens, though, if you do not do that, if you leave it to the District, you are going to end up—and we have already had the commissioner quoted—you are going to end up with a single-payer plan. You are going to have the District of Columbia Government running the health care system in this District, and you are going to see a lot of people moving out of this town. This is the reality. And it is not to put down anybody who lives in this town. The cost of living here is high. The cost of medicine here is incredibly high. The social costs, as we covered yesterday in the Finance Committee, are very, very high. It will not be through any fault of their own, but they are going to go to a single-payer system, and we are all going to line up at the DVM down here, and a lot of folks who can afford not to do that are not going to do it.

I think you could make a difference if you go back and examine the Federal Employee Health Benefit Plan as a way to help people who live in this entire area change the way health care is delivered so we do not have that discrimination against the high-cost District of Columbia area.

Ms. FEDER. Yes. Again, I would say that essentially, as we use District providers, we are paying costs now. We are paying for uncompensated care; we are paying the costs for the academic excellence we have in this city; we are paying those costs in our current health plans.

What we are talking about is a broader distribution of those costs, with subsidies available to offset costs for individuals, and for private employers, for whom this may be newly costly.

I think we have a risk-spreading operation included in the plan, and what I meant to indicate was that we think that essentially, building on the positive lessons of the Federal employee plan, improving it, creates some opportunities for building broad community plans. So we will just continue to discuss it.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Dr. Feder, we are all enormously grateful to you for your involvement in this issue, which is of such great concern to all Americans, and for your enormously thoughtful responses to a lot of the questions. I think you can tell that we all continue on this learning curve, and we could not have a better teacher. We are grateful to you.

Ms. FEDER. Thank you, Senator. It is a pleasure to work with you.

The CHAIRMAN. Thank you very much.

Leading off the second panel two is Judy Waxman, director of government affairs for Families U.S.A. Families U.S.A. is a strong advocate for consumers in the health care system, and we look forward to her testimony.

Leslie Cummings is deputy director of the California Managed Risk Medical Insurance Board, which operates the purchasing alliances for small business in California.

Sean Sullivan is president of the National Business Coalition on Health. He is here today representing the Jackson Hole Group.

Jeff Smedsrud is here representing the Coalition for Voluntary Health Alliances, a group whose members include Communicating for Agriculture, where Mr. Smedsrud is employed, and a number of business groups and insurance companies.

Elliot Wicks is a senior fellow at The Institute for Health Policy Solutions here in Washington.

Finally, Robert Laszewski will testify on behalf of Health Policy and Strategy Associates here in Washington.

Mr. Laszewski used to head up Liberty Mutual based in Massachusetts, so we are delighted to give him a special welcome.

We will begin with Ms. Waxman. If you could attempt in your opening statements to follow a 5-minute rule, we would appreciate your cooperation.

STATEMENTS OF JUDY WAXMAN, DIRECTOR OF GOVERNMENT AFFAIRS, FAMILIES U.S.A., WASHINGTON, DC; LESLIE CUMMINGS, DEPUTY DIRECTOR, CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD, SACRAMENTO, CA; SEAN SULLIVAN, PRESIDENT AND CEO, NATIONAL BUSINESS COALITION ON HEALTH, WASHINGTON, DC, REPRESENTING THE JACKSON HOLE GROUP; JEFF SMEDSRUD, EXECUTIVE VICE PRESIDENT, COMMUNICATING FOR AGRICULTURE, WASHINGTON, DC, REPRESENTING THE COALITION FOR VOLUNTARY HEALTH ALLIANCES; ELLIOT K. WICKS, SENIOR FELLOW, THE INSTITUTE FOR HEALTH POLICY SOLUTIONS, WASHINGTON, DC; AND ROBERT L. LASZEWSKI, PRESIDENT, HEALTH POLICY AND STRATEGY ASSOCIATES, WASHINGTON, DC

Ms. WAXMAN. Good morning, Senators.

I appreciate very much your invitation. You specifically asked me to testify from the consumer point of view about consumer predictions in this alliance system, and although my written testimony does not indicate this, I do want to support what Dr. Feder said in terms of a mandatory alliance.

It seems to us that the problems consumers face right now are in large part due to the segmentation of the market, and to companies picking certain people to cover, the healthier people, the people who will not need coverage, the people who they even think might not need coverage in the future, and by having voluntary alliances, you will perpetuate that system.

One of the best predictions for consumers would be to recreate a community-based system where risk is spread among all the consumers in the area and thereby protects all of the consumers in that way.

In my testimony, I do talk about another most important consumer protection, and that was alluded to earlier, too, and that is the fact that the theory of these alliances is that they should be consumer run. In fact, the plan that we have seen does have an extensive requirement for consumer participation on the alliance boards, and we would like to see that strengthened to make the consumers the majority and to emphasize the nonprofit nature of those entities.

Consumers are going to be the ones purchasing the insurance, they will be the ones using the insurance, and they should be the ones in the driver's seat.

I would also like to mention that we do think there should be a requirement to make the consumer boards somewhat representative of the community, and by that I mean almost any of us could be called a consumer. We think there should be some attention to making some diversity requirement such as representing broad ethnic, geographic, and socioeconomic demographics in the community, because in fact different consumers do have different needs.

My written testimony mentions quite a number of different aspects of the plan as it is written, and I just want to mention a couple in the short time I have. One is the ombudsman that is supposed to be located within the alliance. We think that is a crucial kind of program that could go a very long way to educate, act as a patient advocate and problem solver for consumers.

I do want to note that the funding is not secure as I read the plan, and we think that there should absolutely be secure funding for an ombudsman office. And I recommend that you look at the nursing home ombudsman program that exists now in every State to see what kind of national standards you might want to create for that ombudsman program.

I would also like to note that we understand an enhanced grievance appeal procedure at the alliance level is under consideration, and we think that is important because the ombudsman can be a great problem solver, but it does not replace the need for standardized grievance procedures.

I also want to note that Families U.S.A. is very pleased to see that the alliance will be charged with reviewing marketing materials. If the system is going to be driven by the consumer having the choice and having the information, those materials should be accessible to the community and accurate, and the alliance role here could be very important.

The last consumer protection I would like to highlight is the ability of the consumers to choose among plans. Now, the whole system that we have set up here does allow for the consumer to pick, and again that is another reason for the mandatory alliance. Right now, as an employee of a small business, in fact a nonprofit organization, I have no choice of plans. I can only pick the one that my employer picks. But of course, even Families U.S.A. as an organization has no choice in plans; because of our medical history, there is only one plan in the whole country that will serve us.

So under the system that you set up with these alliances, we think all of us as consumers will be at an advantage to be able to pick among a variety of plans.

I do want to add one cautionary note. Also as we read the plan, low-income people are going to be given a choice among some of the plans based on premium subsidies, but the cost-sharing requirements may negate some of those premium predictions. Right now, as we read the plan, there is no protection for low-income people for high cost-sharing plans, and therefore, their choice will be limited in that way. Additionally, if someone is a family that makes about \$10,000 a year, the requirement of \$10 per visit or \$5 per prescription for everyone could really make it impossible for that family to pick any plan but the one that would waive the fees or really have no choice to go to the provider when they need it.

What we are trying to do here is protect all consumers, so we suggest that you look carefully at establishing some more cost-sharing protection so that indeed all consumers have a choice.

In conclusion, I would like to say that the creation of the alliances can indeed bring about a new era in consumer decisionmaking and consumer control, and if the alliances truly represent all the consumers, we think it can make a new system that is truly responsive to all consumer needs.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Waxman follows:]

PREPARED STATEMENT OF JUDY WAXMAN

Mr. Chairman and Members of the Committee: Thank you for inviting me to testify this morning. Families USA is a national non-profit organization which advocates for health care reform on behalf of consumers.

You have asked me to testify about the role of the health alliances in providing consumer protections as proposed in the President's health care plan (The American Health Security Act.) The consumer-controlled health alliances created by the plan will play the central role in assuring that all individuals within their communities get affordable health care under the reformed health system. The alliances have responsibility for representing the interests of consumers and purchasers of health care services; for structuring the market for health care to encourage the delivery of high-quality care and the control of costs; and for assuring that all residents in an area enroll in health plans that provide the nationally guaranteed benefits. The following are some of the strengths of the proposed system with our suggestions for improvements where appropriate.

COMPOSITION OF ALLIANCE

Under the American Health Security Act, the board of each alliance must include an equal number of employer and consumer representatives, plus an additional member who serves as chairperson. Among the types of consumers who must be represented on the alliance are: employees; self-employed individuals; and other individuals who obtain coverage through the alliance. The board of an alliance may not include anyone who derives substantial income from health plans or the provision of health care services or supplies; or members of associations, law firms or other organizations that represent the interests of health care providers.

Families USA strongly supports the extensive requirement for consumer participation on the alliance board. Because consumers are the purchasers and users of insurance, they are in the best position to negotiate with health plans and to assure that the information consumers need is provided. We would strengthen this section by requiring that the consumers be generally representative of the ethnic, geographic and socio-economic demographics of the people in the alliance. We think this requirement is important to assure that the members of the alliance represent a wide spectrum of interests which may not otherwise occur.

OMBUDSMAN/ADVOCACY PROGRAM

The plan requires that every alliance has an ombudsman and that states may establish a one dollar premium contribution check-off to support the ombudsman or consumer advocacy representatives.

The inclusion of an ombudsman is crucial to assure that consumers have an advocate they can turn to when any problems arise with their health plan. The role is so critical that funding should be secure and not dependent on variations that might occur with a premium check-off. This office should have sufficient resources to address fully the needs of local consumers.

We understand that an enhanced grievance appeal procedure at the alliance level is under consideration. We support expedited reviews that will help the consumer get quick resolution to disputed concerns, such as denials of care.

We also suggest that there be national standards for the role of the ombudsman so that all consumers will have access to consistent assistance no matter where they live. Additionally, the ombudsman must be given authority to report problems to the state or other entity that has monitoring and sanction responsibilities.

Congress should look at the current ombudsman program for nursing home residents to evaluate its strengths and weaknesses. Important lessons can be learned from this program.

History of health programs that included consumer representatives taught us that consumers can make a valuable contribution. However, they often need technical support and a secure base of supporters in order to maximize their effectiveness. For example, our experience with health planning boards indicates that sometimes consumer representatives were overwhelmed by the expertise of professional colleagues on the board. Support should be provided so that the consumer members of the alliance board can get the technical assistance they need. Additionally, the consumer check-off for consumer representatives should be enhanced to assure a sufficient level of financial support for local consumer advocacy.

ROLE OF ALLIANCE

The Health Alliance is charged with negotiating with plans, managing enrollment, providing consumer information, risk adjustment, increasing access and administer-

ing subsidies. All of these responsibilities are integral to protecting the interests of consumers.

For example, to assure that consumers are well-informed about the health plan choices, the alliance is charged with approving all marketing materials for the plans and distributing easily understood useful information that allows individuals to make comparisons between plans. The role of reviewing marketing materials will help assure that the claims made by the plans are accurate. Unfortunately, plans have sometimes used misleading information to recruit members. The alliance's review of all materials is an important new consumer protection.

Another new protection is the requirement that alliances distribute report cards. For the first time consumers will get to compare health plans on quality measures that are easy to understand. Since all plans will offer at least the same comprehensive benefit package, the report card will compare similar plans, yet help the consumer decide on the best plan for him or her. To be most useful the information must be easily understood by a variety of different consumer populations.

Another important role of the alliance is to assess the adequacy of the availability of health services in the alliance area. Under the President's plan, the alliance may use financial incentives to increase access in underserved areas. One suggestion to strengthen this section is to require that alliances must find ways to increase access where providers of care are scarce. Even though health plans are required to demonstrate that they can provide care to all members of the health alliance, alliances are in the best position to assess where the weakest areas are in their alliance and to create incentives to remedy the problems.

The alliance is also charged with administering the subsidies for low-income individuals, families and small businesses. The efficiency of the administration of this role will determine whether universal coverage is achieved. We know that low participation in means-tested programs has been a problem historically. Simple procedures will be necessary to ensure that the people and businesses that need the subsidies will obtain coverage. The alliance must not create barriers that would result in delayed or denied coverage.

CHOICE OF PLANS

The most important role of the alliance is to negotiate with health plans within its communities for the exact premium the plan will charge. Alliances, after negotiating with providers, will establish fee schedules for fee-for-service health plans. Under certain circumstances, alliances may decline to enter into contracts with specific health plans. The alliance is charged with assuring that the plans stay within the alliance's budget and thereby assure consumers that plans will be affordable.

The process of negotiation will result in a variety of plans that consumers can choose from. The "open season" which is managed by the alliance will allow consumers to enroll in the plan of their choice. The element of choice is a crucial consumer protection. Enforcement by the states of quality standards is also, of course, integral to the assurance of quality. But for the first time, consumers will be able to make some determinations on their own of what plans they want to join and thereby create an incentive for plans to provide higher quality care.

One cautionary note must be added. Low income people have no or very little choice under our current system. Under the alliance, there seems to be a choice of at least some of the plans for lower income people who are on cash assistance and for those lower income people not on cash assistance. However, the institution of cost sharing for all low income people could negate the premium protections.

We understand that the Administration is currently considering to allow health plans the option of waiving cost sharing for certain population groups. This method of protecting low income people will not work. If, for example, only one plan agrees to waive the cost sharing for low income people, then all low income people will choose that plan. They will in effect have no choice. Cost sharing subsidies as well as premium protection must be established to assure that low income people have choice in plans.

CONCLUSION

The American Health Security Act provides the framework of numerous protections for consumers. The creation of alliances will bring about a new era in consumer decision making and consumer control. If the alliances truly represent the heterogeneous consumer interests of the communities they serve, this structure could make the health system truly responsive to the needs of the consumer.

The CHAIRMAN. Ms. Cummings.

Ms. CUMMINGS. Thank you, Chairman Kennedy and committee members. I am glad to be here with you and talk with you a little bit about the Health Insurance Plan of California, which we opened on July 1, and what lessons it might be appropriate to draw from what we have done in California to what you are thinking of doing here with health alliances.

Senator DURENBERGER. It was very clever to get the acronym, "HIPC."

Ms. CUMMINGS. Well, actually, it was shortly after we chose that name that everybody changed the name to health alliances. [Laughter.]

The HIPC opened July 1. It was authorized in statute, which was requested by Governor Wilson in California and was carried by Assemblyman Burt Margolin. It occurred in the context of a market reform in the small group market. Within that context, there is guaranteed issue, guaranteed renewability of coverage, limits on pre-existing conditions, etc.

The pool was authorized as a voluntary pool, and our board was given broad authority in its design. When designing it, the board chose to draw on many of the concepts of managed competition that you have been hearing about here. These include employee choice of plan, standard benefit plan design, and fiscal incentives for employees to choose lower-cost plans.

We contracted with one company to do our enroller and marketing functions, and a number companies, 18 companies, to provide health coverage; three are PPOs, and the rest are HMOs. The rates that we charge are low. Our lowest rates undercut the market by about 15 percent when we opened.

Now, having provided you with this background on the HIPC, what comments would we have about the construct of health alliances? The first one is that employee choice does seem to be a very desirable feature in the market. We chose to do it because of its long range cost containment possibilities, but we have found that in the small employer market, it is one of our biggest selling features.

Much has been said today about the administrative costs of alliances and fears about bureaucracies, and I would like to comment on that. In the small employer market in which we operate, because our present target is employers of 5 to 50 employees, the amount of administrative costs that they pay in their premium is about seven times higher than of very large employer groups. So it seems clear to us that it is possible to, by concentrating market share, remove some of the administrative costs.

In the HIPC, what we charge is about 3 percent of premium. We think that that represents the high end of what alliances would have to pay. That is because our market is particular; in the small group market, you have lots of interactions with employers and employees, because they do not have their own health benefits staff and because there are so many of them.

Also, when we negotiated our administrative prices, we had no enrollment. Our company that took on our enrollment and premium collection did so speculatively, and we think that when we actually have expanded and have a lot of enrollment, we will be able to do better in our prices.

Then, third, because the HIPC is voluntary, we have to market ourselves and try to attract people into the program. That costs us money, too.

We think the low end of what alliance administrative cost might be is shown by our "big sister" agency, CAL-PERS in California. Theirs are about 0.6 percent of premium. Now, they are also a different environment than the alliances would be operating in, but we think it shows sort of what the low end will be. We think that alliance costs would be somewhere in between because they will have some of the problems that we have—small employers, individuals, and dealing with the private sector—but they will also get the benefit of very high volume and big groups.

I would like to note that alliances can be implemented quickly and show fast results. Our authorizing statute—we were up and running within 9 months of its enactment, and on the day that the market reforms took effect. We did a lot of work during that time and operated our other two programs, but when the law went into effect, we were there. We met our deadlines, had our coverage available in the market, and provided high-quality, low-cost care.

It is not necessarily the case that all alliances would be able to come up that quickly. We have the benefit of lots of managed care companies in California, and we also as a staff have had experience with our other two programs, doing this negotiations. But we think it shows that alliances can come up a lot more quickly than some people seem to be saying.

I have heard a lot this morning about concerns about the creation of new bureaucracies, and I would like to talk with you a little bit about how we do business.

We have a five-member board, and we have 13 staff right now. One of the reasons that our staff level is so low is that we contract out all of our operational functions so that enroller premium collection and all that sort of thing is contracted out as well as the providing of health coverage.

We like this way of doing business because it enables us to hold our contractors accountable and let us focus on policy and monitoring of our contracts. We think that it is a system that works very well for our subscribers.

We would also like to note that our governing entity, our board, is one for which there are no special interest-designated spots. Our board includes people who have connections with the business and health insurance world, although none of them have current ties to the health insurance industry. We think it is important that there not be designated spots. We think that is something that can cost you a lot of time in trying to get your board to make decisions. We have been able to be as fast as we have been because of our excellent board.

We also think that health alliances will be accountable to purchasers if they are run by purchasers, and that it is important to have conflict of interest requirements.

Another comment that I would make is that we think that consumers are best-served when what is being competed on is quality and price, and not risk selection.

In all of these variations that you have heard about voluntary pools, small regional pools, competing pools, we are concerned that

what you will see is competition on risk, and we think that is something to avoid. It is something that has ruined the market as you see it now, and can definitely be created in the future, even in the context of the stronger market reforms that are proposed by the President.

We think that the best way to avoid risk selection is to have a big pool, an exclusive pools, and a statewide pool. We ourselves use a construct; we have statewide coverage, but regional offerings, and we think that that is an approach that allows us to charge regional rates, but to avoid some of the risk selection issues that you have heard about today.

Multiple pools also result in duplicate administrative costs; this is obvious on its face, and I do not think I need to go into it much except to also note that when you have competing pools, you are also creating the need to do marketing costs.

My last comment is one that I really have not heard talked about today, but what kind of voluntary pool to extend coverage to the uninsured by itself. Robert Wood Johnson Foundation studies, I think, have clearly shown that all by themselves, access to care is not going to produce a large expansion of coverage to the uninsured. Our experience supports that. Eighty percent of the coverage that we have sold so far is to employers who have previously been insured. And our 20 percent rate of selling to the uninsured is, we think, to be expected because the market reforms for the entire market, letting medically uninsurable employers come into the market, just started July 1st.

Assuming, however, that 20 percent was the number that it stayed over the course of the next several years, how far could we go covering the uninsured in our pool? Well, there are about 4 million uninsured small employers in California. We will be pretty happy if we get to 70,000 enrollees by the end of this next year, and if we doubled that by the following, we would be serving about 7 percent of the uninsured through the HIPC. So I think it is pretty clear that by themselves, voluntary alliances would not make big inroads in covering the uninsured.

To summarize, we want to say that we think alliances are not just theoretical constructs. We are by no means a full-fledged alliance, but we see shadows of it in ourselves, and we have been able to do what is requested of us and get it done fast and get it done in ways that are responsive to our purchasers. We think that the President's proposal can work and that his proposals will work the best in an environment of exclusive large pools.

Thank you.

The CHAIRMAN. Thank you very much, Ms. Cummings.

[The prepared statement of Ms. Cummings follows:]

PREPARED STATEMENT OF LESLEY CUMMINGS

Chairman Kennedy and committee members, My name is Lesley Cummings and I am the Deputy Director for the Managed Risk Medical Insurance Board, commonly known as MRMIB, which recently opened a purchasing pool for small employers in California. It is a pleasure to be with you as you focus on what is, perhaps, the most essential construct in the President's health reform proposal—health alliances.

The MRMIB staff believe that health alliances can achieve the purposes envisioned for them by the President. We have worked through a number of the issues intrinsic to the health alliance construct while designing and implementing Califor-

nia's purchasing pool, and we hope that our experience and views will be useful to you as you consider the President's proposal.

BACKGROUND ON THE HIPC

The Health Insurance Plan of California, or the HIPC, opened on July 1, 1993, and as of October 1, 1993, it had enrolled over 1,000 small employers and 15,000 people.

Authorization for the HIPC occurred in legislation which reformed the small employer health insurance market in California. The legislation, requested by Governor Pete Wilson and carried by Assemblyman Burt Margolin (D-LA), enacted market reforms which ensured guaranteed issue and renewable coverage for all products sold in the market and established rate bands and limitations on pre-existing condition exclusions. Additionally, it authorized MRMIB to establish a voluntary purchasing pool in the reformed market.

The legislation gave the board broad authority to establish the HIPC's design. In structuring the HIPC, the Board drew from the following managed competition principles: Use of a standardized benefit plan design which must be offered by all participating health plans. Use of an "employee choice" model in which the employee chooses annually from among the participating plans. Use of participation requirements which provide employee fiscal incentives to choose lower cost plans.

MRMIB contracted with one company (Employers Health Insurance) to perform enrollment and marketing functions for the HIPC, and with 18 companies (15 health maintenance organizations and 3 preferred provider organizations) to provide health coverage. We have statewide coverage and, in the vast majority of the state, employees can choose from numerous health plans. For example, in Sacramento, employees can choose from among 14 plans. We have major "name brand" plans, as well as regional HMO's with limited service area. A list of our participating plans is attached.

The rates that we negotiated with plans are extremely competitive with those available outside the HIPC. Our lowest rates undercut the market by approximately 15%.

POSSIBLE LESSONS FOR HEALTH ALLIANCES

Having provided you with background on the HIPC, I'd like now to discuss what we have learned in our experience at MRMIB which may be relevant to the national debate on health alliances.

The HIPC's employee choice feature has proven to be extremely marketable and 15 clearly valued by our enrollees.

We selected employee choice because it is critical to a long term strategy for cost containment. In making this decision, we anticipated that employers and employees would welcome choice, especially in the small employer market where the opportunities for choice have been very limited. We have found the employee choice feature to be one of our biggest selling points.

Alliances can reduce administrative and marketing costs.

In the small employer market in which we operate and in which the vast majority of the uninsured work, administrative costs are up to seven times higher than those of very large employers. Thus, it seems apparent to us that concentrating functions in one location does in fact reduce administrative costs that we required our contracting health plans to remove from their premium prices. In the HIPC, we charge employers \$20/group and \$2.50/enrollee per month, fees which equal slightly less than 3% of our average premium. Included in these amounts are the costs of enrollment, premium collection and marketing (absent agent fees) as well as MRMIB staff costs. Our costs represent the high end of what an alliance's administrative costs would be. This is because our market is comprised of very small groups with virtually no in-house employee benefit staff. This type of business is relatively expensive to administer compared to large groups with in-house benefits staff.

When we negotiated our administrative prices, we had no enrollment. The higher the number of enrollees, the less administrative costs are as a percentage of premium. The next time we renegotiate our administration contract, we will be able to obtain lower prices assuming our enrollment has reached sufficiently high levels.

Because the HIPC is voluntary, we market to attract business. We are spending about \$3 million/year for direct sales staff, ads and billboards.

At 0.6% of premium, our "big sister", the CAL-PERS program, probably represents the lower end of administrative costs. CAL-PERS enrolls some smaller groups but also has other extremely large groups to balance out its costs, does not have to market itself, uses staff in the various personnel offices of state and local

government offices to assist in the processing of enrollment paperwork and generally benefits from the economies of scale which come from being an established pool with over 800,000 enrollees.

We think the President's alliance structure should produce significant administrative savings over the current system and will probably cost somewhere in between CAL-PERS and the HIPC. Alliances will not have to incur the cost of marketing themselves, but will be enrolling a mixed population of individuals, small groups and large groups, private sector businesses and public sector entities. Because they will be exclusive, they will have really very large numbers of enrollees and thus will be able to take advantage of economies of scale. And, like CAL-PERS and the HIPC, alliances will be using standardized benefit plan designs which significantly reduces the amount of information that has to be generated about coverage details. I should say a word about a major administrative/marketing cost center—agent costs. The issue of agent reimbursement proved to be a significant issue for us and may prove to be so for you. Agents are a major presence in the small employer market. They are the primary way by which coverage is now sold in the marketplace. Many small employers want to take advantage of agent services because they lack in-house benefits staff. However, agent commissions also represent a major factor in the higher administrative costs of small employers.

In the HIPS, we allow for agent reimbursement. However, the costs of agents are not included in our premium prices. Employers choosing to use agents pay fees as a specific add-on to premiums, in amounts set by the Board. By allowing employers who wish to purchase directly to do so, and by reducing the amount of compensation agents receive through the set fee, we have reduced the cost of coverage for employers significantly.

If the President's health reform proposal is enacted, many functions now performed by an agent would be eliminated or significantly altered. In an environment of guaranteed coverage and community rating, there is no longer a need for someone who is familiar with the details of carriers' particular underwriting habits. When health plans use standardized benefit plan designs and all health plan rates are published in a single booklet, there is no longer a need for someone to analyze differences in benefits plan designs and scout out lower rates. However, there will still be a need for consumer education, particularly as millions of previously uninsured people, most of whom are in the small group market, will be obtaining coverage for the first time. It may be appropriate for agents to play a role in these consumer education activities.

Alliances can be implemented quickly and show fast results.

We opened the HIPC to enrollment nine months after enactment of the authorizing legislation and on the day the law took effect. In that time, staff drafted regulations, the Board held numerous public hearings on the regulations, the Board adopted regulations, staff drafted model contracts, staff conducted negotiations with 7 companies for the enroller contract and over 30 companies for our health plan contracts, the Board signed contracts with 19 companies, and staff, working with our contractors, produced enrollment materials and health plan information. We met our deadlines, had our products available in the market as the law went into effect and provided coverage with high quality and very good prices.

We do not suggest that alliances can be operational in all states within similar time frames. We in California are fortunate to have a large number of managed care plans, many of whom wanted to be in the pool. We also profited from the fact that staff at MRMIB had experience negotiating with plans for our other two programs California's high risk pool for medically uninsurable people and a subsidized health insurance program for low income pregnant women. However, we believe that the speed with which the HIPC became a reality here in California shows that using the alliance concept need not mean years delay while these organizations come into existence.

Alliance operations can be streamlined, responsive and unbureaucratic.

We think that certain features of our organization could be used to ensure that alliances are responsive and efficient.

Role of staff: Our Board views the role of MRMIB staff as being policy-makers, negotiators, contract monitors and ombudsman. All operational functions, such as collection of health premiums, enrollment, and provisions of health services, are contracted out, using contracts with terms allowing for financial penalties or contract cancellation if performance becomes unsatisfactory.

Because of its reliance on contractors to perform operational functions, MRMIB presently operates its three programs with just 13 staff. Even though the HIPC's

enrollment is growing at the high end of our enrollment estimates, we intend to add only one position through 1994-95.

We think that use of performance-based contracts would help alliances achieve high levels of performance, keep the in-house staff small in number and allow the staff to remain focused on essential tasks.

Governing Entity: Appointments to our Board are not divvied up among different special interest groups. Our Board members have background in business or health insurance but have no current ties to the health insurance industry. In fact, statutory conflict-of-interest requirements preclude any member of our Board from having such ties.

We believe that health alliances will be accountable to purchasers if they are run by purchasers. We think it is extremely important that the alliance boards not be established with one slot for each interest group. We support the type of conflict of interest requirements that the President's plan includes.

Consumers will be best served when competition is on quality and service rather than risk selection. This fact argues against small regional pools, competing pools and voluntary pools, all of which are plagued with risk selection issues.

One of the reasons that health care is in such a mess today is that carriers have been able to make a lot of money by insuring only people who weren't going to incur significant costs. The whole market has been structured to reward risk avoidance.

Guaranteed issue and community rating requirements begin to change those incentives, but they are not sufficient if carriers can take some action—such as choosing to participate or not participate in a given pool—to obtain a better risk selection. Obviously, the risk selection issues are the most serious in a voluntary pool environment. But they can be significant with alliance competition and even where there are a number of small regional pools.

In the voluntary market in which the HIPC now operates—improved though it has been by the recent reforms—carrier behavior is still motivated by the desire to sell to low-risk groups. Even under the stronger market reforms proposed by the President, carriers will still be able to figure out a way to segment risk unless the market is structured in a way that does not allow for the subdividing of major population groups. A single, statewide, exclusive pool allowing for regional health offerings is probably the best way to avoid risk segmentation and maximize alliance benefits.

Multiple pools would result in duplicative administrative costs.

Clearly, there are duplicative administrative costs that would result from establishing competing or small regional alliances.

Each of the alliances would have to incur administrative costs for staff, offices, data systems, phones, and office supplies.

Where there are competing alliances, the alliances also would have to incur marketing costs to attract purchasers to their own entity.

Voluntary alliances will not be able to make significant progress in covering the uninsured

Enacting market reform and establishing voluntary alliances provide access to coverage. But, as the Robert Wood Johnson Foundation studies have shown, access alone does not result in a significant expansion of coverage for the uninsured.

Our experience supports this finding. Eighty percent of the employers purchasing coverage through the HIPC were previously insured and changed coverage because the HIPC was a better deal for them. We expected to have a significant number of uninsured come into the market July 1 when the guarantee issue requirements took effect. It is unclear to us what the percentage of uninsured will be when the market settles down a bit.

However, using the present 20% figure and extrapolating to the small employer market, we note that there are 8,000,000 lives associated with the small employer market in California half of whom are uninsured. If we have 70,000 enrollees in the HIPC by the end of the present fiscal year and double enrollment the next year, we will still be covering only 0.70/6 of the uninsured through the HIPC.

CONCLUSION

To summarize, the experience we have had in establishing the HIPC shows that alliances are not just theoretical constructs. The HIPC is by no means a fully developed alliance, but even in its more modest form, it has shown that employee choice is valued in the private market, administrative savings are achievable, and efficient operation is possible. The President's proposal for exclusive, large pools protects the

alliances from the dangers and costs of risk selection and allows for additional administrative and marketing savings.

PARTICIPATING HEALTH PLANS

PPO's

Aetna; Employers Health; John Alden Life.

HMO's

Aetna; CIGNA Healthplans of California; Contra Costa Health Plan; FHP, Inc.; Health Net; HMO California; Kaiser Foundation Health Plan (No); Kaiser Foundation Health Plan (So); Life Guard Group Health Care; National Med; PruCare of California; QualMed California; SCAN Health Plan; Sharp Health Plan; TakeCare; United Health Plan.

The CHAIRMAN. Mr. Sullivan.

Mr. SULLIVAN. Mr. Chairman, Senator Durenberger, I am Sean Sullivan, president of the National Business Coalition on Health. We have 70 coalitions around the country, representing about 5,000 employers and about 25 million insured Americans.

We are an active participant in the Jackson Hole Group that has developed the managed competition approach to health care reform, and I am here today on behalf of that group. I am especially pleased to be presenting this testimony to you on their behalf, because we have member coalitions around the country that are proving the worth of the alliance concept. In fact, I think we may have coined the term as well, in some of our communities around the country.

We have been demonstrating that this is not just a theory, but it is indeed an eminently practical way to reduce the cost and improve the quality of health care if it is done the right way.

The Jackson Hole Group welcomes President Clinton's stated support for managed competition as the best way to achieve the goals of health care reform, and we are ready to work with him to pursue those goals.

With respect to alliances, however, the President's proposal as it now stands is an example of what Alain Enthoven, one of the originators of the idea, has recently called "a good health care idea gone bad." If all but the largest employers were forced into regional alliances as the administration proposes, the Nation would have a virtual single-payer system that would control prices instead of reducing costs through the dynamic of competition among providers to satisfy the demands of private purchasers for better value.

In the Jackson Hole design, cooperatives are intended to serve as a pooled purchasing arrangement to spread risk for small groups, give their members access to the competitive market for health care that has been created by larger groups that are driving improvements in quality and reducing costs. Cooperatives are not intended to take over the functions of creating and perfecting markets for larger employers and regional coalitions that are already doing this. They are designed to give small groups and individuals the same advantages already enjoyed by larger ones, without concentrating too much market power in the hands of a quasi-public entity which could then dictate prices to health plans and destroy the competitive dynamic created by multiple purchasers getting plans to compete on the basis of price as well as quality.

The risk-spreading function of alliances does not require them to incorporate most of the population in a region. The President's pro-

posal would incorporate as much as 80 percent of the population or more in most parts of the United States. Risk-spreading can be done over much smaller populations, with special adjustments made for health plans, as is proposed by Jackson Hole as well as the President.

It is not necessary to create virtual purchasing monopolies to deal with the risk selection problem and thereby sacrifice the competitive gains in quality and cost efficiency being realized by keeping most purchasing in the hands of private employers in any given marketplace.

In contrast to the President's proposal, the Jackson Hole design calls for keeping the alliances much smaller, limiting them to small employers and individuals who cannot effectively participate in the competitive marketplace. The cut-off size, as opposed to the administration's proposal of 5,000 or fewer, could be 100; it could be even smaller, as proposed by other bills now before the Congress, without preventing this alliance from performing its necessary functions. These lower numbers would still put enough workers in it to make it viable as a risk spreader and a pool purchasing arrangement.

Keeping the alliances smaller would keep the balance of purchasing power in each region in the hands of cost-conscious consumers and private employers who are already driving the market. I could testify first-hand about the experience and successes of our coalitions in communities like Memphis, Orlando, and Denver, in making less costly, better quality care available to the entire community, from large companies like Federal Express and Walt Disney to smaller ones like the City of Longwood, FL, and the Lodge at Vail in Colorado. These are dynamic purchasing groups, and in other communities as well, they are already proving the value of a managed competition approach to let private purchasers get the best out of the health care delivery system and drives the formation of the kinds of accountable health plans that the President as well as the Jackson Hole approach talk about, and it is one of the keys to reform.

The body of experience that we are accumulating suggests that national reform should build on these practical demonstrations of how managed competition already works, rather than replacing them with the huge alliances that have yet to prove that they could do nearly as well.

Another advantage to keeping the alliances smaller is that they will do a better job at serving their consumers who would have someplace else to go. Jackson Hole originally favored exclusive alliances. It does propose that employers below a certain size should be in an alliance. But on reflection, it now seems wiser to allow small groups and individuals to have some choice as well among alliances in their area.

Exclusive alliances would be under no pressure to perform as well, since their members would have nowhere else to go. The inevitably bureaucratic nature of all these kinds of entities suggests that absent any need to justify what they do, over time, they will tend to serve their own interest rather than those of their members. So for this reason, it seems wise and fair to offer small groups at least some choice among alliances in a region.

The immediate objection to this, of course, is the concern about risk selection, but I think that can be dealt with through the risk adjustment process already being proposed for accountable health plans.

As a final note, this enterprise of setting up alliances on the scale and in the time frame anticipated by the President is a vast undertaking. For this reason alone, I think it would be wise not to make the alliances nearly so all-encompassing as the President is proposing. The functional equivalences of alliances that are already demonstrating they can work in places like Memphis, Colorado, and CAL-PERS took years to get to the success level that they are now demonstrating. There is too much at stake to plunge the entire system into the kind of new world being proposed by the President. It is not necessary to do this. If we go back to the approach that came out of Jackson Hole, where the idea of alliances originated, and build on the examples around the country that I have referred to, we can bring all Americans as soon as possible into a system driven by the right kind of competition—that to improve the value of every dollar spend on health care.

For the record, I am also leaving here a copy of a new paper by Professor Alain Enthoven and Sara Singer on the subject of co-operatives and alliances.

The CHAIRMAN. Thank you, Mr. Sullivan.

[The prepared statement of Mr. Sullivan follows:]

PREPARED STATEMENT OF SEAN SULLIVAN

Mr. Chairman and Members of the Committee: I am Sean Sullivan, President and Chief Executive Officer of the National Business Coalition on Health, an association of 70 coalitions around the United States representing more than 5000 employers of all sizes and more than 25 million insured Americans. We are an active participant in the Jackson Hole Group that has developed the managed competition approach to health care reform, and I am here today on behalf of that Group to present our views on the critical subject of health plan purchasing cooperatives, or alliances as President Clinton has called them in the administration's proposal. I am especially pleased to be presenting this testimony on behalf of the Jackson Hole Group because some of our member coalitions are already proving the worth of these alliances, in their communities—demonstrating that this is not just a theory, but an eminently practical way to reduce the cost and improve the quality of health care.

The Jackson Hole Group welcomes the President's stated support for managed competition as the best way to achieve the goals of health care reform, and we stand ready to work with him in pursuit of those goals. With respect to alliances, however, the President's proposal as it now stands is an example of what Alain Enthoven, who with Dr. Paul Ellwood and Lynn Etheridge originated managed competition, has recently called a "good health care idea gone bad" in the pages of the Wall Street Journal. If all but the largest employers were forced into regional alliances as the administration proposes, the nation would have a virtual single-payer system that would control prices instead of reducing costs through the dynamic of competition among providers to satisfy the demands of private purchasers for better value health care.

Roles of Alliances

In the Jackson Hole design, cooperatives are intended to serve as a pooled purchasing arrangement to spread risk for small groups and give their members access to the competitive market for health care that has been created by larger groups driving improvements in quality and reductions in cost. The cooperatives are not intended to take over the functions of creating and perfecting markets for the larger employers and regional coalitions which are already doing these things. They are designed to give small groups and individuals the same advantages enjoyed by larger ones without concentrating too much market power in the hands of a quasi-public entity, which could then dictate prices to health plans and destroy the dynamic cre-

ated by multiple purchasers making plans compete for their business on the basis of price as well as quality.

The risk-spreading function of alliances does not require them to incorporate most of the population in a region. The Clinton proposal would require workers in all firms with fewer than 5000 employees to purchase their coverage through a single alliance, which means that these alliances would represent more than 80 percent of the population everywhere in the nation. Risk spreading can be done over much smaller populations, with special adjustments made for health plans that end up with a disproportionate share of high-risk enrollees. It is not necessary to create virtual monopoly purchasing pools to deal with the problem of risk selection, and thereby sacrifice the competitive gains in quality and cost efficiency to be realized from keeping most of the purchasing in the hands of private employers in any given community.

Similarly, the legitimate role of alliances in "managing" competition does not require them to be huge. They can enroll members, publish comparative information on health plan prices and quality, and do the risk adjusting for health plans without becoming so big that they suppress the natural competitive forces that are given freer play in a decentralized marketplace of multiple purchasers as well as plans.

Appropriate Size of Alliances

In sharp contrast to the President's proposal to put all but the employees of the largest companies in the alliances, the Jackson Hole design calls for keeping the purchasing cooperatives much smaller—limiting them to small employers that cannot effectively purchase in the competitive marketplace. The cutoff for the size of firms whose employees must be in the cooperative could be 100, as it is in the bills introduced by Congressmen Jim Cooper and Fred Grandy and by Senator John Chafee, or 50 or even 25 without preventing the cooperative from performing its necessary functions. These much lower numbers would still put enough of the workers in the cooperative—from 25 up to 50 percent in most areas—to make it viable as a risk spreader and pooled purchasing arrangement.

Keeping these alliances much smaller than the President's alliances would keep the balance of purchasing power in any region in the hands of increasingly cost-conscious consumers and private employers who are already driving the market to reduce costs and improve quality. I can testify firsthand about the successes of established business coalitions in communities such as Memphis, Orlando, and Denver in making less costly, better quality care available to employers large and small—from Federal Express to Seesel's Supermarkets, from Walt Disney to the City of Longwood, and from Coors to the Lodge at Vail with 37 employees. These dynamic purchasing groups and others in Minneapolis, Miami, and a dozen more communities are already proving the value of a managed competition approach that lets private purchasers get the best out of the health care delivery system. They are getting hospitals and doctors to integrate their services, improve their quality and efficiency, and reduce their costs—making them into the competitive accountable health plans that are a key to the Jackson Hole approach. This growing body of experience suggests that national reforms should build on the practical demonstrations of how managed competition works, rather than replacing them with huge alliances that have yet to prove they can do nearly as well. For managed competition to work most effectively, it is imperative to maintain competition among purchasers—large businesses and coalitions as well as the alliances—and not just among providers. Private purchasers will demand more of health plans, and will be the source of innovation and dynamism in getting better results from them.

There is another advantage to keeping the cooperatives smaller—they will do a much better job of serving their members. The President's alliances would be huge quasi-public bureaucracies, on the order of regional departments of health, with potentially several million enrollees in some of them. This should give anyone pause who has ever tried to get quick satisfaction from any large bureaucracy. If we want to increase consumer satisfaction with the health care system, this is not the way to do it.

Exclusivity of Alliances

The original Jackson Hole design called for the regional cooperatives to be the exclusive vehicle for those in smaller groups to purchase coverage, and the President's proposal also calls for exclusive—albeit much larger—alliances. On reflection, it now seems wiser to allow the small groups and individuals who must be in the cooperatives to have some choice as well. Exclusive cooperatives would be under no pressure to perform their roles well, since their members would have nowhere else to go. The inevitably bureaucratic nature of all such entities suggests that, absent any need to justify what they do, over time they will tend to serve their own interests

rather than those of their members. For this reason, it seems wise and fair to offer small groups at least a modicum of choice between cooperatives in each region. This will keep the cooperatives on their competitive best behavior, and better serve the interests of the members.

The immediate objection to non-exclusive cooperatives is that they will lead to adverse risk selection: if there are two in a region, one will end up with the good risks and the other with the bad. This is a legitimate concern, but it can be dealt with through the risk adjustment process. Just as accountable health plans would receive risk-adjusted premiums based on the characteristics of their enrollees, the cooperatives could be required to help subsidize each other on the basis of risk distributions so that one would not be bankrupted paying health plans higher premiums for its higher risk members. As in the case of determining how large the cooperatives should be, concerns about risk can be addressed without sacrificing the competitive dynamic that leads to constant improvement in performance.

Final Cautionary Note

Setting up alliances on the scale or in the time frame anticipated by the President's proposal is a vast social and economic undertaking. It will require large amounts of time, energy, and resources, and the savings from doing so will be slow in coming. For this reason alone, it would be wise not to make these alliances so nearly all-encompassing as the President proposes. The functioning equivalents of such alliances that are now demonstrating such good results—coalitions such as the Memphis Business Group and the Colorado Alliance and other groups such as the California Public Employees' Retirement System (CalPERS)—took years to achieve the successes they are now demonstrating. There is too much at stake to plunge the entire health care system into a social experiment that could end up failing badly, with enormous consequences for the American people. The magnitude of savings being counted on by the administration from creating a set of huge quasi-public alliances to squeeze waste out of the delivery system cannot be realized without doing harm to the quality and availability of services Americans are used to. It is not wise to go down this path.

Fortunately, it is not necessary either. Gradual implementation of the time managed competition approach of the Jackson Hole Group, relying heavily on expanding existing successes in the marketplace rather than replacing them, can get the nation where it wants to go without risking the quality of our health care. We can continually reduce costs and improve quality by using the principles of managed competition already being demonstrated around the United States as the basis for reform, bringing all Americans as soon as possible into a system driven by the right kind of competition—competition to improve the value of every dollar spent on health care. To do this, we must turn back in the direction of the market-based approach to reform that has been put forth out of Jackson Hole, and is already emerging in many parts of America.

Note: For the record, I am making available a new paper on health plan purchasing cooperatives by Alain Enthoven and Sara Singer.

The CHAIRMAN. Mr. Smedsrud.

Mr. SMEDSRUD. Mr. Chairman and members of the committee, my name is Jeff Smedsrud. I am executive vice president of Communicating for Agriculture, a national rural association that represents about 80,000 farmers. We have had a long involvement in health reform, including helping some 27 States set up risk pools for those who have been denied insurance.

I am here today on behalf of CA and representing the Voluntary Purchasing Cooperative Coalition, a broad-based and growing group focused solely on the issue of the structure of cooperatives and health alliances. CA and many other business associations including National Small Business United, the Retail Federation, and National Association of Wholesalers, formed the Coalition to ensure that the freedom to make health care choices does not become a casualty of a reformed health system.

Let me be very clear. There are distinct advantages to businesses and individuals pooling together in health cooperatives. Farmers believe in coops. Businesses are forming purchasing groups. But al-

ways, we do so with the belief that consumers, and not the Government, will manage and run the cooperative or purchasing alliance.

Simply stated, mandatory health alliances become monopolies. Monopolies will stifle competition. Lack of competition can limit choice, and limited choice can reduce quality.

In my home State of Minnesota, it is the growth of voluntary alliances that are making us a model. Let me give you a few examples.

In Red Wing, MN, a river town of about 15,000, a community-led initiative pooled large and medium-sized businesses together improved care while bringing costs down. Pulling the community together helped save local jobs. That is a part of the reform that needs to be looked at, especially in rural America.

Forty-nine rural hospitals, some of which are in North Dakota and South Dakota, are in the process of partnering with insurers and employers to create their own voluntary regional alliances. They plan to operate it as a true cooperative. Ninety cents on the dollar is planned to go back to pay the claims. No part of it is going to be based on risk selection.

And finally, while many large businesses have for years in Minnesota formed powerful networks, a group called the Employers' Association pooled some 80 small and medium-size firms together, and the result is a 3-year guarantee of very stable prices.

But it is not just in Minnesota. All across America, new voluntary alliances in many shapes and sizes, going by many different names, are changing the face of health care. We the people are forging our own rules, and with common rules, standard practices, a level playing field, and a reformed market, we will continue to find better solutions than could be achieved by having a Government monopoly and its exclusive alliances.

Voluntary alliances are working to solve the health care crisis, but they need to get a helping hand from a Government that attempts to nurture change instead of control it. Without question, Americans ought to be guaranteed access to insurance, and Government can guarantee it. We ought to have rules for alliances, and Government can write and enforce those rules. In short, we do not believe that the Government needs to run the health care system in order to make it better.

That is especially true in rural America. Out in the country, many rural associations offer plans for their members—groups like the wheat growers, the soybean people, the corn growers, veterinarians, the National Grange, CA. For many Americans like those, the message of mandatory alliances boils down to this: We will not let you keep the plan you now have, even if you like it more and even if it costs you less.

Instead of tearing down those existing association plans, why not use them as a base to do an even better job than they have done in the past? If pooling arrangements are working in the private sector—in many cases, they are working very well—why replace them with a new, Government-sponsored system that is yet essentially unproven?

When Florida reformed its market, it created guaranteed access and it created voluntary health alliances. When California reformed its market, it created voluntary health alliances. Texas and

Iowa, to name a few States that are looking at reforming their markets, are creating voluntary health alliances.

Let me give you a couple quick reasons on why voluntary alliances make a lot of sense, and voluntary cooperatives. First of all, it maintains an employer's ability to control choice and maintain a role in negotiating the best deal for those employees. It retains freedom of choice. It puts control over how to solve health problems in local people's hands, and it maintains existing valued relationships. And finally, it creates true competition on a very fair and level playing field.

Coming to the hearing today, I was reading *Business and Health*, and there are two articles in this month's issue on solutions for small business, talking about the growth of voluntary alliances and how new alliances are changing the health care system. I think we are seeing a lot of change all around the country, and I think we need to encourage alliances, but make them voluntary.

Let me conclude by raising a couple of quick points on some of the specific rural issues. We have a real concern that the way the President's plan is drafted, it would prohibit health plans from offering different rates based on geography. Rural residents, where basic medical costs—we are not talking about insurance administrative costs—basic medical costs are less, may end up subsidizing their city cousins. States that have made progress on reform have acknowledged there are very distinct differences in baseline medical costs between rural communities and urban, and we do not want rural to subsidize urban.

Our fee-for-service plan is really an option. Fee-for-service is still the primary method of insurance in rural America. Managed care has not always been viable. The fee-for-service plans would be allowed, but only under a fee schedule set by the alliance. Even though there is a choice of a variety of plans, or a claim to a choice of a variety of plans in an alliance, the alliance would have the right, if a plan was not successful in keeping its costs in line, to shut down that plan, move people to a different plan or, in rural areas, select one health plan, and it, the alliance, to designate that health plan as the exclusive provider in a rural area.

Finally, I think we need to look at the impact of very large alliances on rural communities. If the idea of alliances is to squeeze down costs, there is a tremendous incentive to find efficiencies. One of those efficiencies might be closing down rural hospitals. There is a likely transfer of jobs and medical facilities to regional centers as a result of these alliances. Funding from the President's plan comes from cuts in Medicare; that is going to have a big impact in rural areas.

Last, let me close on the whole question of the National Health Board. It strikes many of us in rural America that a seven-member National Health Board will have enormous powers. If a State cannot live within its budget, the board has the right to change the system. It can move States toward a single-payer system. And we sincerely question how a small board like that will serve minority interests, such as rural interests, and how we will be given a fair shake in this entire plan.

I will close by saying that the choice for rural people is clear. We sincerely believe that we need to lead change by continuing to forge

new and innovative voluntary local cooperatives that will work for us and be built by us.

Thank you.

The CHAIRMAN. Let me just ask on the choice, is that made by the employer or the employee under the program you are talking about?

Mr. SMEDSRUD. Essentially by the employer.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Smedsrud follows:]

PREPARED STATEMENT OF JEFFREY SMEDSRUD

Mr. Chairman and members of the committee, my name is Jeff Smedsrud, and I am executive vice president of Communicating for Agriculture, a national rural association that represents about 80,000 farmers, ranchers and rural small businesses.

I am here today on behalf of CA, and representing the Voluntary Purchasing Cooperative Coalition, a broad-based and growing group focused solely on the issue of the structure for cooperatives and alliances.

CA has had a long involvement in health reform. For 17 years we have helped create state risk pools for those denied insurance for health reasons. This week, we brought the directors of the 27 states that operate these programs to Washington, DC, for our annual conference.

Last week, we organized a conference in Washington that was co-sponsored by 10 other national rural and commodity associations. More than 100 farm leaders worked together to examine the impact of various health reform proposals.

CA, and many other business associations, including National Small Business United, The National Retail Federation and The National Association of Wholesalers, in conjunction with a number of carriers, formed the Coalition to ensure that the freedom to make health care choices is not a casualty of a reformed health system.

Let me be clear. There are distinct advantages to business and individuals pooling together in health cooperatives. Farmers believe in cooperatives. Businesses have formed purchasing groups. Consumers have created buyers' markets. But always they do so with the belief that consumers—and not the government—will manage and run the cooperative or purchasing alliance.

Simply stated, mandatory health alliances are monopolies. Monopolies stifle competition. Lack of competition limits choices, and limited choice can reduce quality.

In my home state of Minnesota, the growth of voluntary health alliances is one of the reasons we have become a national model.

Let me review a few of Minnesota's shining stars:

In Red Wing, a river town of about 15,000, a community-led initiative pooled large and medium-sized businesses together and improved care while bringing costs down. Why did they do it? Because smart-thinking local leaders knew that jobs were being lost, because more and more of the local health dollars were migrating to Minneapolis or Rochester. Pulling the community together and working with people to get their care locally put more money into the local economy.

In rural America, health care reform must be but jobs—creating jobs, not losing them in the name of large-scale efficiencies.

Forty-nine rural hospitals—some of which are in North Dakota and South Dakota—are in the process of partnering with insurers and employers to create their own voluntary, regional alliance. The goal is to operate the plan as a true cooperative, and see 90 cents on the dollar go back to pay the medical costs. It eliminates duplicative administrative functions, and develops community profiles to deliver the types of services that best meet local needs. They will utilize data to manage costs and change practice parameters. No part of it will be based on risk selection.

And finally, while many large businesses have for years formed powerful networks, a group called The Employers Association has pooled 80 small and medium-sized firms into a voluntary network. The result: a three-year guarantee of very stable prices.

Across America, new voluntary alliances—in many shapes and sizes, with differing names and structures—are changing the face of health care. We, the people, are forging our own American solutions to the health care crisis. And with common rules, standard practices and a level playing field, the people—and a reformed mar-

ket will continue to find better solutions than would ever be achieved by government monopolies.

Voluntary alliances can help solve the health crisis but only if they get a helping hand from a government that attempts to nourish change, not control it.

Without question, all Americans must have access to health insurance—and government must guarantee it.

Without question, there should standards for alliances—and government should write and enforce the rules.

Without question, tax policy should be fair and suitable and government can make it so.

Without question, technology and data play significant roles in improving care and lowering costs—and government ought to remove barriers.

In short: Government doesn't have to run the health care system in order to make it better. Mandatory alliances will be giant, regulatory monopolies that will not serve the best interests of rural America. We will be better off if we grow our own solutions.

Out in the country, many farm and rural associations offer excellent plans. Groups like The National Association of Wheat; The American Soybean Association; The American Veterinary Medical Association; The National Grange; CA; to name but a few.

For many Americans, the message of mandatory alliances is this: You won't be able to keep the plan you now have, even if it costs you less and you like it more.

Instead of tearing down existing association plans, why not use them as the base to do an even better job?

If pooling arrangements are working in the private sector—and in many cases they are—why replace them with a new government-sponsored system that is unproven?

When Florida reformed its health market it created new health purchasing pools. But it does not make them mandatory.

In California, many small companies are joining a new health insurance purchasing cooperative. The state chose to make the pool voluntary—not mandatory.

Texas and many other states are working to encourage purchasing cooperatives—but they won't be mandatory.

Let me give four sound reasons to encourage voluntary; competing purchasing cooperatives:

1. It maintains an employer's ability to control cost and retain a role in negotiating the best deal. Employers don't want to hand-over employees to a government-run alliance—and then pay 80 percent of the cost with no negotiating role.
2. They retain freedom of choice. If the cooperative doesn't do a good job, people have the right to go somewhere else.
3. It puts control over how to solve health problems in the hands of local people and maintains existing, valued relationships.
4. It creates true competition on a fair and level playing field.

I'd like to conclude my remarks by highlighting several troubling points of the President's plan—in addition to the aspect of voluntary vs. mandatory alliances—that will be challenging for rural Americans. I do so on behalf of CA, and not the coalition. I raise six questions:

1. Are the Standard Benefits Too Good?

The President's plan will require all individuals to purchase a plan with generous benefits and low deductibles, and the plan will be community-rated. Farmers tend to buy a plan with high deductibles and "self-insure" for routine, nonemergency expenses. The President's plan means more insurance with more benefits, but it may also raise the costs for some. Shouldn't more individual flexibility be allowed?

2. Will Rural Subsidize Urban?

Because the President's plan would prohibit health plans from offering different rates based on geography, rural residents—where basic medical costs are less—may end up subsidizing their city cousins. States that have made progress on reform have acknowledged the need for urban vs. rural differentials as part of modified community rating.

3. Are Fee-for-Service Plans Really an Option? How Much Choice Will There Be?

Fee-for-service is still the primary option in rural America. Managed care has not been viable in many areas. Fee-for-service plans would be allowed in the President's plan, but only under a "single payer" fee schedule set by the alliance.

And even though the alliances claim to give choice of plan, if a plan wasn't successful in keeping its costs in line with other plans, the alliance could move people

into more cost-efficient plans, against their will. In rural areas, the alliance may choose a plan for us.

4. What Is The Economic Impact For Rural Communities?

In the President's plan, large alliances will, in theory, hold down costs by improving efficiencies. Rural residents are worried about the likely transfer of jobs and medical facilities to regional centers, accelerating the demise of small town hospitals and very small communities. If small town hospitals—often the largest employer in a community—are forced to close, it will cause jobs to be lost, and diminish the prospects of bringing new jobs to the community. Funding for the President's plan comes, in part, from cuts to Medicare and Medicaid. These cuts will have a disproportionate impact on rural hospitals.

5. Will the Incentives For New Providers Really Help Underserved Areas?

Rural areas face a critical shortage of medical personnel, and the average age of doctors is higher than in urban areas. Incentives are clearly needed. However, some incentives in the President's plan are linked to the designation of an area as a federal Health Professional Shortage Area. Areas that meet the HPSA designation have access for incentives: those that just miss the cut-off do not. In addition, areas that use the incentives to recruit physicians face the loss of the designation after three years, creating instability to an already fragile system. In addition, the use of physician-to-population ratios as the measure to allocate resources may not always be appropriate when the need, for example, is additional nurses or physician extenders.

6. National Health Board: Too Much Power In Too Few Hands?

Surveys by CA and others point out that people are skeptical both of too much government intervention and of too little. But what is the proper mix?

The President's plan would create a seven-member national health board that will have enormous powers. If states cannot live within budgets established for them by the National Health Board, the federal government could intervene and either move the state toward a single-payer system or impose new requirements on businesses and providers in that state. And how will minority interests—such as rural areas—be given a fair shake by a board that will likely be dominated by urban, large-scale interests?

The choice for rural residents is clear: We can either lead change by forging new, innovative, voluntary, local cooperatives or we can be herded into plans dominated, controlled or designed by others. Encourage health cooperatives, but let them be voluntary. Thank you.

The CHAIRMAN. Mr. Wicks.

Mr. WICKS. Thank you, Senator.

I am Elliot Wicks, senior fellow at the Institute for Health Policy Solutions. The Institute is a small, nonprofit agency engaged in policy research, and we focus on health reform policies that combine roles for the public and private sectors, especially alliance-type organizations. We have provided technical assistance to several States and a number of business coalitions trying to implement collaborative purchasing arrangements.

I appreciate the opportunity to share my views with you on the functions and structure of health purchasing alliances. I need to stress, however, that the opinions I offer are my own and may not coincide with those of my colleagues at the Institute.

Let me begin by looking at one of the ways in which I think alliances can bring advantages to the system and their ability to broaden consumer choice.

When individuals enroll through the alliance, they, rather than their employer, decide which health plans best meet their needs. They have a choice of all plans under contract to the alliance. In contrast, employees of firms that purchase coverage on their own are limited to the health plans the employer chooses to offer. Increasingly, employers, even larger ones, are limiting the number of plans they offer, often to only one or two.

Today, many plans require enrollees to use network providers or impose financial penalties for getting care from out-of-plan providers. So having the employer make the choice of health plans is often equivalent to having the employer select the providers that will be available to employees. Most people would not want employers to choose where they send their children to school, where they buy groceries, or what lawyer they consult. Having employers limit choice of health plans could be seen as a similar imposition.

Individuals who purchase health plans through the health alliance face no such restrictions. Moreover, this kind of consumer choice is consistent with the way we normally think competition should be driven in our economy. We assume that the ultimate arbiters of which kind of products succeed in the market and which producers succeed or fail are the preferences of consumers, and only in a system where consumers ultimately make those choices do you get that kind of competitive result.

A second major advantage of having people purchase coverage through the alliances is that it allows them to sustain provider relationships over time. When people enroll in a health plan through the alliance, they are assured of continuity of coverage because coverage is not linked to employment. Their employer cannot decide to drop one plan and choose another. If they lose their job, change employers voluntarily, or move in and out of the labor force, they do not have to change health plans and develop new provider relationships. Such portability of coverage and continuity of care is not ensured for people employed by firms who buy coverage outside the alliance.

Let me just give an example of the potential importance of this question. My wife's employer in the last 4 years has had three different health plans. In the first one, they offered several HMOs and a freedom of choice plan. They changed that to a plan by a single insurer, and it offered several kinds of options within that. But an umber of people had to drop the HMOs that they were previously in and change to this plan. And now they have adopted yet a third plan, dropping the second one, and a number of people are again going to be required to change providers because they were in managed care plans.

One of the questions which has been raised about alliances and has had some discussion this morning is whether participation in the alliance should be compulsory or mandatory. Should employers have the option of purchasing coverage outside the alliance? I believe they should not.

Even with reforms in the rules governing insurance marketing and premium-setting, it may not be possible to eliminate risk selection if employers can opt out. Because of the myriad of techniques insurers can use to attract good risks and avoid bad risks, and the very strong incentives for doing so, and the very large number of individual contracts that would exist when employers can opt out, effective enforcement would require a large regulatory bureaucracy and might even then be impossible.

Moreover, when employers arrange for coverage on their own, employees do not have free choice of plans, nor is portability of coverage assured.

Finally, the consumers, the ultimate users of health care, do not drive competition because they do not have the opportunity to decide which plans offer best value. When employers make that choice, that choice may not coincide with the one consumers would make for themselves.

Another question which has received much attention this morning is whether a region should be served by only one alliance or by several competing alliances. Obviously, the intent of having multiple alliances is to provide choice so that consumers can reward good alliances and penalize bad ones. I think this is not likely to happen, however. Consumers will interact primarily with their health plans, not the alliance. They are not likely to change health plans and give up established relationships with providers just because they do not like the alliance. The kind of activities that the alliance undertakes generally are not going to be very visible to consumers, other than providing information about plans. For the most part, the other things, most consumers are not going to pay much attention to because it does not affect them very directly. What does affect them is their interaction with their health plans, and they are unlikely to say, "I do not like this alliance, and therefore I am going to drop my health plan and get a different one."

Now, you could solve that presumably by having every alliance offer every health plan, but that would certainly be confusing to consumers, and the choices they are going to face are already daunting enough; to ask them to make a choice of one health plan offered by two different alliances, it seems to me would be unduly complex and not very useful.

A third question is should larger as well as smaller employers be required to purchase coverage through the alliance. In part, the position one takes on this issue depends on the priority one assigns to allowing individuals to have a broad choice of health plans and assurance of portability. Individuals employed by middle-sized firms will not have a wide range of plan choice if the employer decides which plans to offer. Individuals will not be assured of being able to maintain long-term relationships with providers if coverage is purchased outside the alliance; and consumers will not be the driving force behind competition if their employers select the source of coverage.

I believe that the issue of larger employer participation is more than a technical question of finding an appropriate cut-off point. The decision about employer size goes to the heart of the nature of system reform. Are alliances to be the fundamental mechanism through which people get coverage, through which the system is monitored and administered, and through which costs are controlled, or is health care to continue to be characterized by a very large number of different employer-based health plans?

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Wicks follows:]

PREPARED STATEMENT ELLIOT K. WICKS

I am Elliot Wicks, Senior Fellow at the Institute for Health Policy Solutions. The Institute is a small, non-profit policy research agency that focuses on health reform policies that combine roles for the public and private sectors, especially alliance-type

organizations. We have provided technical assistance to several states and a number of business coalitions trying to implement collaborative purchasing arrangements.

I appreciate the opportunity to share my views with you on the functions and structure of health purchasing alliances. The opinions I offer are my own and may not coincide with those of my colleagues at the Institute.

The alliance concept was originally conceived as a solution to the failures of the market that is supposed to provide health coverage for small employers. The failures are well known. Insurers compete through risk selection rather than by finding ways to make health care delivery more efficient. Small groups finding themselves with a few very sick people discover that no one will insure them, or they face such high premiums that coverage becomes unaffordable. Costs are not equitably spread, and many people are left unprotected.

In addition, any small firm represents such a small portion of a health plan's business, that the firm has no bargaining power. It cannot negotiate with health plans to get a better deal.

Alliances are a mechanism for curing both problems. Insurers under contract to the alliance would now be covering larger aggregations of people and basing the premium on the experience of the group as a whole. Premium differences would be greatly reduced, and premiums would be more stable over time. The alliance represents a sufficient share of the market that health plans will have to compete to attract the individual enrollees who purchase coverage through the alliance. Since competition based on risk-selection is no longer possible, health plans must compete for enrollees by being more efficient.

Alliances can also be expected to significantly reduce administrative costs associated with the small-group market. Up to 40 percent of each premium collected from individuals and up to 25 percent of each premium collected for small groups goes to pay for the administrative costs insurers incur in marketing to and servicing this market. Alliance administrative costs would surely be much lower. As the single point for enrolling individuals, collecting and distributing premiums, and providing potential enrollees with information about plan characteristics and performance, the alliance would realize economies of scale that hundreds of insurance companies serving thousands of employers and individuals on a one-to-one basis could not duplicate.

Though designed especially to solve the problems of risk selection, inadequate market power, and high administrative costs, alliances create two other major benefits for the people who buy coverage through them. The first is that when individuals enroll through the alliance, they, rather than their employer, decide which health plans best meets their needs. They have a choice of all plans under contract to the alliance. In contrast, employees of firms that purchase coverage on their own are limited to the health plans the employer chooses to offer. Increasingly, employers, even larger ones, are limiting the number of plans they offer, often to only one or two. Today, many plans require enrollees to use network providers or impose financial penalties for getting care from out-of-plan providers; so having the employer make the choice of health plans is often equivalent to having the employer select the providers that will be available to employees. Most people would not want employers to choose where they send their children to school, where they buy groceries, or what lawyer they consult. Having employers limit choice of health plans could be seen as a similar imposition. Individuals who purchase health plans through health alliances face no such restriction.

A second major advantage of having people purchase coverage through alliances is that it allows them to sustain provider relationships over time. When people enroll in a health plan through the alliance, they are assured of continuity of coverage because coverage is not linked to employment. Their employer cannot decide to drop one plan and choose another. If they lose their job, change employers voluntarily, or move in and out of the labor force, they do not have to change health plans and develop new provider relationships. Such portability of coverage and continuity of care is not ensured for people employed by firms who buy coverage outside the alliance.

One of the questions raised about alliances is whether participation in the alliance should be compulsory or mandatory. Should employers have the option of purchasing coverage outside the alliance? I believe they should not. Even with reforms in the rules governing insurance marketing and premium setting, it may not be possible to eliminate risk selection if employers can opt out. Because of the myriad of techniques insurers can use to attract good risks and avoid bad risk, and the very large number of individual contracts that would exist, effective enforcement would require a large regulatory bureaucracy. Moreover, when employers arrange for coverage on their own, employees do not have free choice of plans, nor is portability of coverage assured. Finally, the consumers, the ultimate users of health coverage,

do not eve competition because they don't have the opportunity to decide which plans offer best value. When the employer chooses, the choice may not coincide with the one consumers would make for themselves.

Another question is whether a region should be served by only one alliance or by several competing alliances. The presumed intent of having multiple alliances is to provide choices so that consumers can reward good alliances and penalize bad ones; but this is not likely to happen. Consumers will interact primarily with their health plans, not the alliance. They are not likely to change health plans and give up established relationships with providers just because they do not like the alliance. Having more than one alliance also creates costly duplication of administrative structures, and the economies of scale that a single alliance brings to the system are diminished.

A third question is should larger, as well as small, employers be required to purchase coverage through the alliance? In part, the position one takes on this issue depends upon the priority one assigns to allowing individuals to have a broad choice of health plans and assurance of portability. Individuals employed by middle-sized firms will not have a wide range of plan choice if the employer decides which plans to offer. Individuals will not be assured of being able to maintain long-term relationship with providers if coverage is purchased outside the alliance structure. Consumers will not be the driving force behind competition if their employers select the source of coverage.

I believe that the issue of larger-employer participation is more than a technical question of finding an appropriate cut-off point. The decision about employer size goes to the heart of the nature of system reform. Are alliances to be the fundamental mechanism through which people get coverage, through which the system is monitored and administered, and through which costs are controlled? Or is health care to continue to be characterized by a very large number of different employer-based health plans?

The CHAIRMAN. Mr. Laszewski.

Mr. LASZEWSKI. It is "Laszewski," Senator. Thank you.

The CHAIRMAN. Thank you.

Senator MIKULSKI. Mr. Chairman, my brother-in-law is Edward Liszewski, with an "Li," so when we go for a vote, I will tell you it is "Laszewski," not "Lazooski."

Mr. LASZEWSKI. Thank you, Senator. [Laughter.]

The CHAIRMAN. I remember one of the wonderful bits of advice that my brother gave me when I was first running for office, and we went to the big Polish meeting in the western part of Massachusetts. He had gone to the graveyard at Monte Casino in Italy, one of the great cemeteries where Polish soldiers, including General Anders, were buried. There were these words: "For your freedom and mine, these Polish soldiers gave their bodies to Italy, their hearts to Poland, and their souls to God. Wlosko Polska, nyeskya nyewa." [Phonetic.]

Senator MIKULSKI. Bravo.

Mr. LASZEWSKI. Very good.

The CHAIRMAN. Thank you. [Laughter.]

Mr. LASZEWSKI. Well, I am Robert Laszewski, president of Health Policy and Strategy Associates, a Washington, DC consulting firm whose clients include health insurers, HMOs, health plan administrators, and employers.

Each of our clients recognize that our health care system is in need of significant policy and marketplace change. They have engaged our services to help them understand and deal with these changes.

The country appears to be reaching a consensus over the need and principles of health reform. This consensus is both long overdue and gratifying. Today I would like to comment on one element of the debate, the issue over whether proposed health insurance

buying pools or alliances should be Government-run monopolies with control over a significant portion of the market, or whether such pools instead should be only one part of a reformed competitive landscape.

I will suggest first that buying pools or health alliances have the potential to be a valuable means with which to assemble large numbers of employers, especially small employers, for the purpose of achieving the kind of expense and spread of health risk efficiencies available to large employers.

Such buying pools, when coupled with group insurance market reform, such as community rating, such as take-all-comers provisions, prohibitions against selective rating, or cherry-picking activities, and guaranteed portability provisions, hold a great deal of promise for making the health care marketplace far more efficient and more fair.

Senator, to your comment, I really believe that we can achieve the noncherry-picking kinds of objectives or the portability objectives without the issue of monopoly or nonmonopoly, because these are rules as to health plans, not buying alliances.

However, as legislators in California and Florida found as they debated monopolistic versus a competitive model, making these buying pools or health alliance monopolies is not necessarily the best policy. In fact, the testimony regarding the California HIPC and its expense efficiency—it should be pointed out this is a nonmonopolistic-style HIPC that is achieving these efficiencies.

Fundamentally, I have difficulty with the notion that only a Government-created bureaucracy can produce better efficiency in the distribution of health insurance, or that the service a consumer receives from an insurer can be improved by putting a Government bureaucracy between the consumer and the insurer. And it would be a bureaucracy, because remember, all premium payment, eligibility, determination of coverage would be handled by this alliance or entity, and that would essentially mean transferring the billing and premium collection duties of an insurance company to the alliance, and that makes for a pretty big bureaucracy.

Now, I may be wrong about all this. I would suggest that the best way to find out whether the Government can in fact construct and operate a buying pool more efficiently, with improved appeal and service for the consumer, is not to exclusively create monopolistic health alliances but rather, ones that compete head-to-head with the marketplace. The problem with going directly to a strategy for monopolistic buying alliances is that once it has been created, there is no going back. If we find that it is simply too bureaucratic and inefficient, we have already eliminated the traditional market.

If a Government-run health alliance is in fact superior to the market, it will win. When I was boy in rural Wisconsin, the coop movement was common; buying or purchasing cooperatives were established on behalf of local farmers. Many felt these coops were the wave of the future in rural retailing. Actually, in order for me to graduate from the University of Wisconsin, I had to take a semester course in the theory of coops. Today, what was once thought as the best way to re-engineer rural purchasing is now a very minor player in the market. It was replaced by a dynamic market

that found a better way to distribute goods in the rural markets—the Wal-Marts of the world.

No one should ever underestimate the power of the market when it is aimed in the right direction. Creating monopolistic alliances would forever eliminate the potential of the market to find a better way. Indeed, a monopoly would eliminate the opportunity to keep the Government itself honest.

Fundamentally, the problem we have had in health insurance is that the power of the market has not been aimed in the right direction. The notion that we need to create Government-run bureaucracies to produce market efficiency does not seem logical to me. I believe that what we need to do is to use the power of the government not so much as a regulator, but as a referee to focus market energy on the objective of reducing cost and improving access to quality health care.

Buying pools or health alliances can be a major part of that effort, but not necessarily monopolistic or bureaucratically-run pools. Competing pools can reduce cost and improve access. To achieve expense and insurance efficiency, pools need only cover about 50,000 individuals, 5 percent of the minimum-size market often cited as necessary for such regional alliances. The actuarial backup for this estimate is included in the documents we have left for staff. They do not have to be monopolies to be big enough.

Second, by mandating that competing plans play by the same underwriting and sales rules inside and outside the Government pool, any successful competitor will have to compete over providing the best cost and quality health product, not over who should or should not be covered.

To ensure that no games are played, many who advocate monopolistic alliances, including the administration, and those who advocate the competitive model have suggested the need for risk adjustment formulas between all competing health plans in a particular region. Such an adjustment formula would essentially level the health risk among plans, assuring that competition only take place over the fundamental cost and quality of the health plan.

I believe that this makes sense, and further I would argue it negates any reason for the health alliance to be monopolistic. Simply, with a risk adjustment formula negating any attempt to game the system, no health plan operating outside the health alliance can undermine the Government-run alliance or any other competitor on any other basis than being able to provide quality health care at a lower price. And isn't that the objective?

The bottom line is that we do not need to go as far as creating a Government-run monopoly to achieve the objectives of alliances or buying pools—efficiency, fairness, and a means to focus the market on true cost/quality results. If we do not need to take the risks associated with creating a Government monopoly, why take the risk of doing irreparable damage to the market? Many of you may not believe that the market is capable of efficiencies on its own; that only a Government-created and operated bureaucracy is capable of running an efficient market. OK. If you believe that, let us put the bureaucrats up against the market, with everybody playing by the same reformed rules, a handicapping system that guaran-

tees nobody can cheat—the risk adjustment concept—and let us see who wins. My money is on the next Wal-Marts of the world.

Thank you.

[The prepared statement of Mr. Laszewski follows:]

PREPARED STATEMENT OF ROBERT L. LASZEWSKI

A central component of several health care reform proposals is the concept of purchasing pools, earlier called "HJPCs" (Health Insurance Purchasing Cooperatives), now called "health alliances."

The expectation is that alliances, representing a group of purchasers, would bring purchasing clout in negotiating health care rates or premiums. Exclusive health alliances would have total jurisdiction in defined geographic areas. Beyond negotiating rates, alliances would:

- Select accountable health plans (AHPs)
- Regulate financial and other aspects of AHPs' rate adjustments
- Use outcome measures to require changes in AHP operations
- Communicate results
- Collect premiums
- Allocate premiums based on performance and other criteria
- Enroll employees and individuals
- Review disputes between individuals and AHPs

All employers with fewer than a specified number of workers would be required to arrange health benefits only through the local alliance; direct arrangements between these employers and health plans would be prohibited or subject to punitive taxes.

Proponents claim that health alliances will give small employers and individuals the market power of large employers, reduce insurance overhead, spread risk more fairly, and provide continuous coverage for workers who change jobs frequently. The concept, while unproven, has attracted the attention of politicians, health economists, insurers, the business community, and health providers.

Because so much of the structure of health care reform will be the result of creating new entities, reform alternatives need to be forced through economic, behavioral, and political models to test out doability. We are dealing with complex assumptions about major structural changes to a system comprising $\frac{1}{3}$ of the domestic economy. As Mortimer Adler was right to warn innovators, "make sure of your assumptions, because if they're wrong, all subsequent decisions will compound the mistake."

This report attempts to provide insights into and issues raised by the concept of exclusive health care alliances as it passes through economic, behavioral and acceptance models or checkpoints.

ECONOMIC MODEL

The central economic issue is if one exclusive purchasing alliance per geographic area will produce the maximum intended financial results.

The overwhelming complexity of today's health care system begs for a full understanding of the economic possibilities associated with any major reform component. This is particularly true because it is impossible to separate one element of the system from all other elements. Thus, a "systemic economic analysis" needs to be performed, despite the fact that pure economic modeling cannot be performed with any full reliability because of the newness of many reform concepts. Without the clear results of extensive experimentation, we are reduced to guessing.

However, significant doubt exists regarding anticipated savings from exclusive purchasing alliances because of:

- a) the untried nature of the concept without adequate experimentation or field testing;
- b) the poor economic results of today's highly regulated insurance markets (workers compensation, private passenger auto);
- c) the lack of competition inherent in a government-constructed/run sole-provider environment;
- d) the disruption of existing private-sector purchasing arrangements now growing rapidly;
- e) the economic impact of establishing a government-run administrative monopoly on levels of cost and service, particularly given recent studies on optimum scales required for cost and morbidity management;
- f) the economic disincentives for new capital to enter a market dominated by a single government selection body;

- g) the possibility of a potentially costly layer of services added to the system;
- h) the possible, even likelihood of "gaming" the system by employers and providers;
- i) insurers prematurely abandoning health markets with the resulting economic costs of government responses.

On its face, the idea of regulating into place exclusive purchasing alliances without extensive experimentation would appear to run significant economic risks. Without adequate research and development as well as pilot experiments, this effort would be the antithesis of how most economic success stories are written. No successful corporation would dare replace a major part of its interface with the customer with an untried concept. The economic or even survival considerations associated with this "leap of faith" would be unconscionable to most successful private enterprises. Even the federal government has recognized the need to thoroughly test drugs before they are permitted to impact the health of the American consumer. It seems incongruous that the federal government would not also wish to test the concept of purchasing alliances before widely impacting the health of the existing health care system.

In economic terms, the central question is which health care reform structure will cause the least amount of near-term economic disruption and provide the greatest amount of economic savings or stimulus. In order to determine the efficacy of exclusive purchasing alliances, it may prove instructive to think of this decision as one being considered by the most effective of economic players, the successful business enterprise. These organizations compete successfully only by bringing products and services to market which are carefully tested before significant amounts of shareholder wealth are invested in the unproven.

There are several examples which one might use to make this point: (Procter & Gamble product research, advertising test markets, TV pilots, etc.) Market research allows the minimum amount of financial and human capital to be invested to create the maximum amount of return. The parallel, of course, is the challenge of spending the minimum amount of tax revenue to produce the greatest amount of health care savings.

Another area of economic concern with the single alliance concept would be the lack of competition inherent in a government-constructed/run environment. It is a given in economic circles that the most efficient method of providing the best possible product at the lowest possible price is to stimulate vigorous competition. Regulated industries have proven to be largely ineffective at producing the most desired economic outcomes. Not only does the concept of an exclusive purchasing alliance eliminate the concept of effective competition at the outset, it raises extraordinary barriers to later entry by future competitors. Even poorly served markets will not be chased by effective competitors without a clear opportunity to ultimately win.

Analyzing the cultures of highly effective competing organizations provides additional insights. When organizations compete, they have a vested interest in stimulating employee environments where creative ideas are stimulated and rewarded, where ambitious people need to accomplish big things, where costs need to be ruthlessly purged from the system and where the customer is truly king and queen. There are few government-run or influenced organizations that can match the standard for excellence and cost levels achieved in competing markets.

Highly regulated insurance markets also provide us with instructive examples of what doesn't happen with heavy government intervention in insurance markets. Here we would turn to two compelling examples, workers compensation and certain auto insurance markets heavily regulated by state governments.

The significant regulation of worker compensation and private passenger auto insurance markets stems from the same imperatives that are reflected by those who want to heavily regulate the health market—the notion that the market has failed to control costs and to provide universal access. Both private passenger auto and workers compensation have been impacted by "out of control" costs and certain high risk individuals or companies are so risky that they cannot find a carrier to take them.

One response by regulators in the property and casualty market has been to regulate prices. The presumption is that if price caps are created, the carriers then would have to respond by figuring out how to better control costs.

Unfortunately, the notion of price caps has little evidence of working. Some of the most price-regulated states have the highest costs. Massachusetts and New Jersey have continually vied for the highest-cost states for auto insurance as rate-regulated states. In workers compensation, over twenty states have established physician fee schedules and yet workers compensation medical costs are no lower than in states

that have no such schedules—studies indicate the providers simply adjust by increasing volume (per Minnesota Department of Labor study).

Price controls simply create a new game for the providers and carriers to play. If rates are set in a political environment, then the best means to achieve profit objectives is to be politically effective. In the auto insurance arena, the game has become a negotiating process between carriers and regulators on what the allowed rate increase will be. Instead of investing more heavily in controlling costs through claim management, the auto carriers have simply focused their efforts on documenting their soaring costs and negotiating next year's rate increase or proportionate decrease in benefits.

While about twenty states have very strong workers compensation, "anti-managed care" laws prohibiting insurers to use many of the accepted managed care techniques, most states do not have such prohibitions. Other states that previously did not allow workers comp carriers to engage in managed care have only recently allowed them to do so.

Since price regulation means everyone must sell for the same price, the only motivation is to produce loss ratios that provide the needed return on investment for the price available. If carriers lower costs and increase profits the regulators would likely want a premium decrease next year. If carriers lower costs and voluntarily decrease rates below approved rates to gain market share, the politicians may take that as a signal to reduce approved rates even farther. They may fear that a political opponent will see market rates being lower than approved rates and charge that this is evidence of poor oversight.

If everybody charges the same rate and the appropriate rate of return is being achieved by competitors through political negotiation, while at the same time greater efficiency only creates downward rate pressure (even if the consumer doesn't fare well), carriers will ask themselves the value of rocking the boat.

More importantly, why would carriers risk any more scarce capital on a business that is at the discretion of a political process?

As another example, by creating government residual pools for those who cannot gain coverage elsewhere, auto carriers are given the opportunity to simply increase their underwriting standards and therefore transfer their worst risks to the government pool. In Massachusetts, we now have 50% of all drivers in the "high risk" pool.

Will such underwriting be unable to occur in a reformed health insurance market? Right or wrong, when the players in the game know the exact parameters of the game, they'll quickly show how to "game" it. If one wanted to move the worst health insurance risks to another carrier's pool, one would only have to create a network that was weak on specialty care, driving the very sick to a network that had the better specialist. If one wanted to achieve a lower-per-unit claim cost, one would only have to move the provider networks to the lower cost parts of an exclusive health purchasing region to bias the selection and lower the claim pool. A risk adjustment formula designed to mitigate one plan having undue risk will not likely be able to adjust for every contingency. The market will always likely be one step ahead.

Proponents' assertions that sole purchasing alliances are necessary in order to streamline administration would appear also to be somewhat questionable. Administering health insurance coverage involves a variety of functions. Some, like claims adjudication and payment performed directly by the insurer, would appear to remain as needed. Other functions, like determining that health services are appropriate and fees are reasonable are done today by many organizations. Fraud prevention is also a critical skill. Other functions are traditionally performed by in-house benefits managers for large employers and by agents or brokers for small employers; these include transmitting premiums, keeping track of enrollment changes, explaining covered benefits, and communicating with the insurer on behalf of insured individuals. These functions must be carried out, regardless of how the system is structured.

It is by no means certain, particularly so without competition, that exclusive purchasing alliances can perform these functions more efficiently and effectively than parts of today's competitive system. In fact, allowing individual employees to choose among all participating plans anticipated under the alliance concept, will increase rather than decrease near-term administrative complexity and cost. Much time and effort will be required to answer individual's questions about all the options available to them; health plans will incur significant costs to communicate directly with their enrollees each time there is a minor change in the plan, such as the addition or deletion of participating physicians. It is potentially more efficient to transmit notice of such changes through employers who can use worksite communications at much lower cost than direct mail. In addition, employers will decrease their benefits

staffs, thus increasing unemployment, while effectively shifting work to the alliance since this will not have a direct employer premium impact.

A parallel economic issue is to what degree existing private-sector efforts to assemble into purchasing groups will be impacted by exclusive government-run health purchasing alliances. In many respects, these purchasing coalitions have already been effective. The economic cost to eliminate or modify these existing structures needs to be understood. To the degree that government steps in front of what is a positive economic result already in place to set up an untried government entity, this certainly should be thought through. Businesses having made progress in this arena won't want to give up their control and gains to an unknown entity and are likely to fight any attempts to nullify those gains.

Exclusive alliances which have administrative functions (see distribution, data analysis, etc.) if exclusive, would also resemble administrative monopolies. Based upon the general level of cost or service efficiency of most government bureaucracies, giving any one entity a monopoly on these efforts would not appear to serve the public.

A pivotal economic question related to the effective pact of administrative monopolies is the assumption that only very large-scale entities can lower costs. Recent studies suggest that more work needs to be done regarding the optimum scale required for morbidity and expense purposes while focusing competitors on who provides the best health care value. Most helpful in the early analysis of this issue is a recent study completed by Walter B. Lowrie, a consulting actuary and Associate Professor of Mathematics at the University of Connecticut, which suggests that the optimum scale for a purchasing alliance can be achieved at approximately 50,000 lives. What this suggests is that it is possible to achieve optimum morbidity and expense scales without exclusive alliances.

This argument would seem to support the premise that, if scale objectives can be achieved, it is almost universally more attractive to have a larger number of competitors fighting for market share in any given market.

Concerns policymakers do have are that players in the system, without exclusive alliances, will play selection games, or that an alliance will simply be undermined through the natural course of the market. While these are risks for both exclusive and non-exclusive alliance approaches, the key is to devise mechanisms for how the anti-selection risk can be avoided. The fundamental issue is how we can be assured that an alliance generally, and health plans specifically, receive a proportionate share of the broader public health risk such that no one is placed in an advantage or disadvantage to the market. While highly complex risk transfer mechanisms have been suggested, they generally appear to be terribly complex and expensive to administer. While clearly more work needs to be done in this area, if analysis suggests that exclusive alliances are too risky a concept to implement without further experimentation, attention can be shifted to work on these other design issues.

From an economic modeling perspective, what primarily drives down costs and improves service is the attraction of new capital and more players to underserved markets. If a single controlling source, such as an exclusive alliance, is seen as standing between an underserved market and a better competitor, the better competitor will stay on the sidelines. What keeps costs down and innovation up is whenever a market doesn't work well and new entrants perceive economic opportunity. An "all or nothing" economic gamble occurs with an accountable health plan entering an exclusive alliance structure. If they're not picked, they're economically dead. Conversely, a competing alliance will succeed only if it finds and attracts more effective new players than those already in the system.

One of the potential hidden economic costs of significant change, particularly in a regulatory-rich environment, is the "gaming" of the system by the players in it. Here are just two examples of how companies might react under an exclusive alliance concept:

- Some companies will aggregate employees in new corporate structures. Healthy workers will be combined to get to the exclusive alliance "exclusion" level. Less healthy populations will be organized in smaller subsidiaries that will stick unhealthy lives in the alliance. This will fix their cost for unhealthy lives and allow them to participate in the good experience of a self-insured plan.
- Differences between states in matters of alliance content or timeframes will induce border area employee migration toward whatever nearby state alliance best serves an employer's interests. This may promote a virtual "arms race" between the states as it relates to alliance design.

Even with highly regulated health alliances, there will be the real opportunity for "approved health plans" (AHPs) to set up networks that de facto underwrite.

- An AHP could decide that it will only contract with certain suburban doctors and hospitals. The AHP could avoid areas of a metropolitan area that contain disproportionate amounts of potential consumers whom they do not want to underwrite.
- Much is made of the potential to "game the system" if exclusive HIPC's are not created. In fact, with exclusive HIPC's, the same gaming can go on. While a plan would have to "take all comers", it would not have to provide a doctor or hospital in their neighborhood.

Of great concern from an economic perspective should be the issue of insurers prematurely abandoning health markets under the exclusive alliance model. This reaction would both diminish interim rate competition, and potentially add significantly to state regulatory costs should states choose to fight such market abandonment and/or rush to provide interim solutions, usually the most expensive outcome.

Within the single alliance concept, an accountable health plan has to also be all things to all people with the possible end result of being mediocre to all markets. Some reviewers of the issue think that multiple, competing alliances could better serve discrete markets such as the senior market, small employers, etc.

Perhaps another alternative in approaching the economic question is to review the parts of the health care reform structure which are likely to have the greatest and quickest leverage on health care costs and refocus efforts on stimulating both the establishment of and increasing the competition between such entities. The ultimate deliverers of competitive health care could perhaps be put in competition with each other sooner. In this regard, it would perhaps appear prudent to analyze the potential of a more rapid establishment of Accountable Health Plans (AHP's), medical outcome databases and administrative cost reform. Here is where real costs are embedded in the system and where acceleration of competition dynamics would appear to bring the largest economic benefits. There are certain reward or punishment structures that might be used to accelerate the establishment of such entities. This would drag other elements of the reform process along if they are successful.

Some alternatives for stimulating such efforts exist:

- Accelerate mandated dates for all key urban AHP's. Cut federal Medicaid support to all states not achieving those goals.
- All accountable health plans set up by an accelerated date receive, through federal mandates, certain rights, privileges or tax benefits.
- All doctors not in accountable health plans by a near-term date would be hit with a 10% income tax surcharge on all non-alliance-generated income.
- Require rural doctors to affiliate with a tertiary care network by a near-term date or receive income tax penalties.
- Compel all hospitals to publish medical costs and outcome data for both the hospital and all affiliated doctors by a required date.
- Require all hospitals, doctors, and insurers to have an electronics claim process in place by a near-term date.

In summary, when pushed through an economic logic model, the concept of exclusive purchasing alliances appears questionable.

BEHAVIORAL MODEL

One great dilemma in bringing significant change to complex systems is that often the players in the system don't behave as anticipated. One or more major groups who react differently than we anticipate or at a different time, can cause a chain of events to occur that diminish or eliminate intended benefits.

The theoretical design of exclusive health purchasing alliances is relatively simple. Purchasing power through an aggregation of buyers is brought to bear on the market. That drives price down and quality up.

An inherent dilemma in this logic, however, may exist in the assumed transition from today's system to a post-transition environment. It is not clear at all at this stage what the transition dynamics will be, particularly so because there are a number of players in today's system with enormous vested interests and millions of connections to insureds through health products and services.

For example, it would appear as if there are massive risks associated with how health insurers will react, in the very near term, to a structure of exclusive health alliances. This concern is based upon previous behavior of the insurance industry, the number of health insurers who are publicly-traded and who have a clear linkage to shareholders' expectations for the preservation of capital and the early evidence of insurer behavior to date in the reform process.

The most dramatic reaction to exclusive purchasing alliances will come from insurers rapidly abandoning health markets followed by consumer reactions when

market vacuums are created. As insurers panic over the prospects of exclusive alliances and attempt to sell or reinsure their existing blocks of business, prices will fall quickly as supply rapidly exceeds demand. If blocks of business have little or no value, or if insurers have to pay to have them taken off their hands, this would cause insurers to simply exit markets, canceling coverage well before any legislated reform outcomes are ready to fill the vacuum.

A collateral dilemma is created because insurers will naturally cancel bad blocks of business before good blocks thus adding higher risk populations to the uninsured population before reform mechanisms are in place guaranteeing insurability. Other insurers will be concurrently reluctant to accept all comers from the early wave of policy cancellations, fearing an onslaught of poor risk experience, just at the time of having a need to spend capital on health care investments. Groups and individuals with poor risk profiles are likely to experience extraordinary difficulty finding coverage or potentially so only at extraordinary prices. The marketplace reaction could be quite volatile.

It is also important to understand insurance industry behavior, both from a past perspective as well as from the context of risk-based capital requirements recently imposed on the industry. The insurance industry has a tendency towards "herd" behavior. This is evidenced by past migrations into risky real estate investments to support higher yields driven by competition for distribution sources, the scramble to enter the financial services business with many subsequent retrenchments and exits and the fratricidal warfare between the stocks and the mutuals over tax positions. There is somewhat of a "me too" syndrome in the industry and a tendency to follow perceived industry leaders, sometimes with disastrous results. The industry is less strategic and more reactive than many other industries. This past behavior, by itself, should concern health reform designers. Exclusive alliances would likely lead to both industry chaos and subsequent insured chaos well before effective regulation exists or an ultimate marketplace shakeout occurs.

Another, more recent industry behavior modifier will be risk-based capital rules adopted by the National Association of Insurance Commissioners (NAIC). Health-based insurers now have a higher capital requirement under the new rules than life and annuity writers. This fact is already begging the question of remaining in health care markets for numerous insurers. Should legislation emerge which tells them there is likely to be little or no role for them going forward based on exclusive alliances, they will rapidly prioritize their available capital needs away from health insurance and move quickly to exit health markets. Publicly-traded companies have an even greater need to move rapidly to show to their shareholders that they are promptly responding to perceived onerous legislation.

While it is impossible to predict the exact form and timing of health insurer responses, it can be reasonably anticipated that exits would occur at a more, rather than less, rapid pace and that resulting market vacuums would drive to the forefront dramatic social and political events.

Anticipating the behavior of health insureds is also difficult, although it is reasonable to assume that, when faced with unanticipated cancellation or transfer of coverage, they will not be pleased. If they panic over losing coverage, their target for focusing fear and anger may be insurers, politicians, or more likely, some combination.

A group of more predictable players, however, are existing health insurance agents, many of whom are active in local and regional politics. When market vacuums are created by insurers rapidly exiting markets, health agents will demand prompt reactions from state legislators. Faced with mounting political pressure, states will likely respond. They will do so by either relieving the situation for insurers, which will perhaps irrevocably damage the concept of purchasing alliances, or become punitive towards insurers voting onerous legislation aimed at preventing companies from exiting markets. This has previously occurred in both California and New Jersey markets when auto insurers sought to leave the state, pending perceived punitive legislation. The recent experience of Allstate in Florida following Hurricane Hugo is another example of how players in the system will behave in unpredictable ways.

POLITICAL MODEL

Identifying in advance likely voter response to a reform scenario is critical to long-term political survival. Underestimating public reaction to what might occur through reform could prove deadly, particularly to those politicians who have visibly campaigned for specific aspects of reform which backfire.

As one example, the business community does not, by a wide margin, support the exclusive health alliance concept. Small business in particular appears violently op-

posed to the concept. In addition, if the concept fails, business will feel that it has been "had" and will also assume they will bear the brunt of any second "fix."

Rightly or wrongly, employers see the dollars that are spent today on health premiums as dollars best controlled by them. Employers have historically provided health coverage as an employee benefit and, while these dollars can theoretically be correctly identified as alternate wages, businesses have a mindset about how those dollars should be spent.

Many businesses see their active participation in the health care arena as one of the reasons that the current health insurance system works well for most employees. They see themselves as advocates for their employees in seeking good health care coverage. The combination of both providing the dollars and perceiving employer value drives employers to compare plans, selecting those which deliver the best overall value and designing coverage specifically to meet the needs of their group, often offering employees a choice among competing plans.

Employers also see themselves as reducing the overall cost of administering health benefits by simplifying communications between the plan and covered employees seeing themselves as much more efficient than any third party.

Employers concerned about rising health care costs have sought creative and innovative ways to provide more cost-effective coverage for their workers. They clearly see themselves as having been and continuing to be more responsive to new ideas for solving health care financing and delivery problems than a governmental or quasi-governmental bureaucracy. As an example, the managed care revolution which has taken place in American health care over the last 20 years, and which continues to develop and evolve dominantly from the business community, has been motivated primarily by employers' demand for better, more cost-effective health care, not government intervention.

Because they pay the high cost of treating illness and injury in lost productivity as well as in insurance premiums, employers also see themselves as the driving forces behind keeping their work forces healthy. Their efforts to encourage healthy lifestyles are a relatively recent but rapidly developing phenomenon and they do not believe that any health care reform system could better their creative efforts in this area.

Employers thus believe that they should continue to select which health plans will be offered to their employees, based on information about the price and performance of competing plans. Most see their contribution of some portion of the cost of the plans being necessary. But, for this, they want to select who provides coverage. They believe that creative pressure applied by employers is the best and most efficient way to change the system.

Any reform concept such as health purchasing alliances that take the responsibility for arranging health coverage away from employers and giving it exclusively to new, untested organizations will not be well received. Employers would continue to pay most of the cost of health insurance for their workers, but they would have no control over what they were paying for. Most employers believe that the decision whether or not to participate in new arrangements should be left to individual employers, not dictated by government.

Small employers who face the prospect of having to provide health insurance, many for the first time, appear to be particularly concerned about having a say in how those dollars are allocated. This is perhaps because of the survival mentality of most small businesses, where every dollar counts. As the small business community is where most of the net new jobs are created, they think of themselves as being more entrepreneurial, creative and smarter than many of their larger brethren. They also have less organizational conservatism and are often led by individuals with strong views and personalities.

The power and creativity of a small business community when faced with political outcomes they view as dangerous, are formidable. One example of this could be seen in 1992 when the state of California proposed a series of health reforms that were widely perceived as being anti-small business. The reaction from the small business community, aided by significant resources from both the health insurance and medical communities was swift and decisive. The California proposal was defeated by a wide margin and has served as a signal to many that the small business community cannot be ignored because of its ability to influence broad voter perceptions and voting patterns.

By far the potentially most volatile players in today's health care system are today's health policyholders. The greatest concern of today's insured population, the overwhelming majority of them employed, is the continuation of today's health coverage. The awareness of health insurance non-portability has skyrocketed in recent years.

Should health reform legislation create a panic among insurers to exit markets, the resulting fear among insureds related to portability will be significant, even if their own personal risk is minimal. More specifically, those losing their coverage or finding group insurance transferred to other carriers, perhaps with lower benefits or higher premiums, will not act kindly to those perceived as causing the problem. It is instructive to look at voter reactions in states where auto insurance operates under rules and regulations viewed as highly punitive by the insurance industry. Not only was there significant political instability while major structural changes were occurring, but there is no evidence to suggest that today's policyholders in those states receive better coverage at a lower price.

From a political risk analysis viewpoint, it may also be relevant that the majority of doctors, hospitals, as well as entrenched medical organization such as the AHA and AMA, appear ready to fight exclusive alliances. From the Administration's perspective, it might be better to co-opt providers on this issue by suggesting that exclusive entities will arise unless competing health plans keep costs low and service high.

Politicians who put all their eggs in the one political basket of exclusive alliances had better be sure that it will work, and quickly. We must remember that it always takes longer to get anything done in a complex political environment, and it's always more costly. One alternative would be to set standards for competing alliances to meet and do everything possible to stimulate the maximum number of players to enter the game. The worst political fallout under that scenario would be that the political process could be accused of attempting to use competitive economic systems before falling back on unproven government structures. On the other hand, if exclusive alliances don't work and no alternatives were tried first, the political backlash could be much more significant.

The ultimate political risk might be the public's reaction if exclusive alliances ultimately fail after much of today's risk mechanisms and capacity are diminished or destroyed, leaving the only viable structural alternative a single-payor health system. This alternative is not favored by a large majority of today's voters and having it occur through political default would have interesting political ramifications.

As a final note, history has provided us, through the public's reaction to the Medicare catastrophic health bill, a valuable lesson. The public will be highly focused and politically vindictive when their personal security is perceived as threatened.

SUMMARY

Implementing the concept of exclusive health purchasing alliances on a national scale without adequate pilot experiments would appear to be risky business. There are large economic, behavioral and political risks associated with "betting the health care ranch" on an untried concept, suggesting a slower, more experimental course.

It would appear reasonable to examine more closely the concept of competing health alliances. Perhaps they should compete with each other as well as with traditional means of arranging insurance under the same market-reform rules. If health coverage available through alliances is better and cheaper, all things considered, employers and individuals will use such alliances rather than more traditional ways of arranging coverage. State-level experiments with alliances might provide concrete examples of what works and what doesn't before betting health care reform on an untried concept.

POINTS OF DIMINISHING RETURN IN A HIPC

INTRODUCTION

There are significant benefits in the formation of large groups of people to obtain health insurance. These large groups of people are currently called Health Insurance Purchasing Cooperatives (HIPC's) or Health Alliances. The benefits that this paper will consider are:

1. Spreading the risk of high medical costs over a mixed group of good and poor risks.
2. Lowering the expense of administration as a proportion of total cost (medical plus expense).

Clearly these benefits intensify as the number of people in the group increases. This paper will show that there are points of diminishing return where a further increase in HIPC size does not give a significant increase in benefits. The points of diminishing return are less than 50,000 lives.

SPREADING THE RISK

We need a way to measure the spread of risk. A good measure is the accuracy to which average medical costs can be determined for a group of a given size. In other words, as a group gets larger its average medical cost can be predicted more accurately. To use the necessary statistical methods, we need to make some assumptions.

We will assume that a group (HIPC or Health Alliance) is formed so that there is no medical cost advantage in joining the group over obtaining medical insurance outside the group. This may be assured if legislation applying to medical insurance plans, inside and outside the HIPC, requires uniformity. This uniformity is with respect to premiums, benefit levels, and provisions such as requiring guaranteed issue of coverage and covering preexisting conditions. Otherwise the healthy people will tend to take the least expensive plans and the sick will tend to take the plans with the most extensive medical cost reimbursement provisions. If there is no advantage to joining or staying outside the HIPC, we can assume that the HIPC has the same cross-section of medical risks as does the non-HIPC group. Then we can use statistical methods that require random selection. Also we will assume that there is no medical cost trend during the year.

Table 1 and Figure 1 give (the same) "99% confidence intervals." These intervals are a measure of predictability of annual medical costs for different size groups. There is only a one percent (one in one hundred) chance that the annual per capita medical costs will fall outside the 99% confidence interval. To further illustrate the idea of 99% confidence intervals, suppose that the average medical cost for people in (say) Connecticut is \$2,200 per person per year. Of course, a particular individual may have annual medical costs anywhere from zero to a million dollars, or more. Imagine we choose a group of 10 people, at random, in Connecticut, and calculate the average annual medical cost in that group. This is done, of course, by adding up the total medical costs, in the group, for the year and dividing by 10. Repeat this sampling process many times. If you tabulate the resulting sample averages, they will center on \$2,200 and 99% of them will be in the

given 99% confidence interval. We use a Normal ("bell-shaped curve") distribution to estimate the 99% confidence intervals. It is a very common practice to use the Normal distribution for this type of estimation.

For example, Table 1 shows that at 50,000 lives, the 99% confidence interval of annual medical costs is \$2,072 to \$2,328 (with a length of \$256). For larger groups, the 99% confidence intervals are not appreciably smaller. If we had chosen a lower confidence level than 99% then the points of diminishing return would be the same as or less than 50,000.

EXPENSE OF ADMINISTRATION

It is difficult to predict the administrative cost of a HIPC since the idea is new. We assume that the HIPC will perform the following functions:

1. Contract with AHP's
2. Set community rates
3. Funnel premiums
4. Coordinate benefits
5. Manage customer relations
6. Create and distribute a catalog
7. Collect data

There will very likely be many AHP's for a given HIPC. The HIPC will not pay claims, be subject to taxation, or incur costs of broker compensation (e.g., commissions, bonuses). The insured people in each subgroup of the HIPC could then choose from a plethora of AHP's. The process of keeping track of who is in which AHP may be expensive. This is particularly so if people change AHP's frequently. Perhaps a "window" should be specified (say the month of September) to limit voluntary changes from one AHP to another. The public will be choosing AHP's based on their personal experience, the AHP's claim settlement efficiency, and the AHP's reputation. If new AHP's are brought in or current AHP's are removed from the HIPC, the necessary movement of people among AHP's would be expensive to administer. Also, there are proposals for the HIPC to collect post-treatment data to analyze the effectiveness of the providers and the types of treatment. The design of these proposed computer systems will be very expensive.

The Pepper commission found that administrative expenses (including claim settlement expenses, taxes and sales expenses) for ten-employee groups, insured for medical costs, were 35% of premium. The corresponding rate was between 4.5% and 5.5% of premium for 1,000-employee groups.

An expense study done at a medium-large (very high quality) mutual insurance company suggests that the aggregate expense rate for medically insured groups (excluding taxes, sales expenses and claim settlement expenses) is about 6% overall. The size of the average group was about 10 employees. Results from other expense studies from the same company were used to estimate expense rates for medium to large sized groups. Approximate adjustments, for the differences between conventional insurance expenses and proposed HIPC's expenses, were applied to the insurance company expense estimates. To verify the expense rates for very large groups we observe that the Medicare administration expense rate, including claim settlement, is four percent of total costs.

The results that emerged, for various sized groups, are shown in Table 2 and Figure 2. These results were interpolated smoothly so that there would be no discontinuities. From Figure 2 it appears that the point of diminishing return is around 25,000 lives. That is, the expense rates do not get appreciably smaller for larger groups.

The expense rates shown in this paper were set at a minimal level. Considerable efficiency will be required to achieve this level in practice. If we had assumed higher expense levels, proportionately, the point of diminishing return would not increase.

Table 1

NINETY-NINE PERCENT CONFIDENCE LIMITS OF AVERAGE
ANNUAL MEDICAL COSTS PER INSURED

Assumes an Average Annual Medical Cost
per Insured of \$2,200

Number of Insured People In HIPC	Lower Limit - 99% Confidence Interval	Upper Limit - 99% Confidence Interval
25	0	7,922
50	0	6,246
100	0	5,061
250	391	4,009
500	920	3,480
1,000	1,295	3,105
2,500	1,628	2,772
5,000	1,795	2,605
10,000	1,914	2,486
25,000	2,019	2,381
50,000	2,072	2,328
100,000	2,110	2,290
250,000	2,143	2,257
500,000	2,160	2,240
1,000,000	2,171	2,229
2,500,000	2,182	2,218
5,000,000	2,187	2,213

Figure 1

NINETY-NINE PERCENT CONFIDENCE LIMITS OF AVERAGE ANNUAL MEDICAL COST PER INSURED

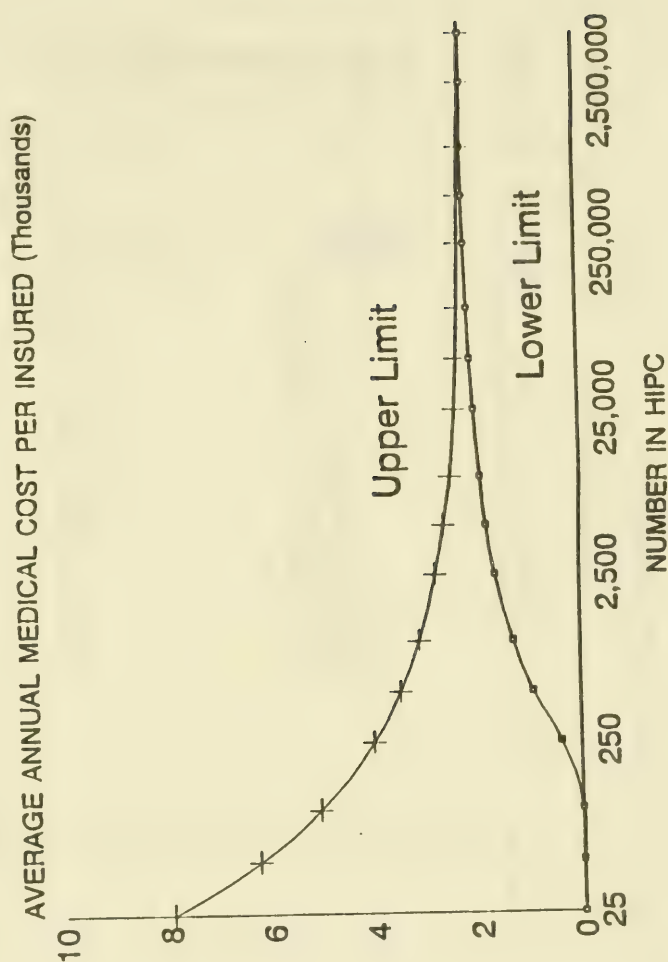


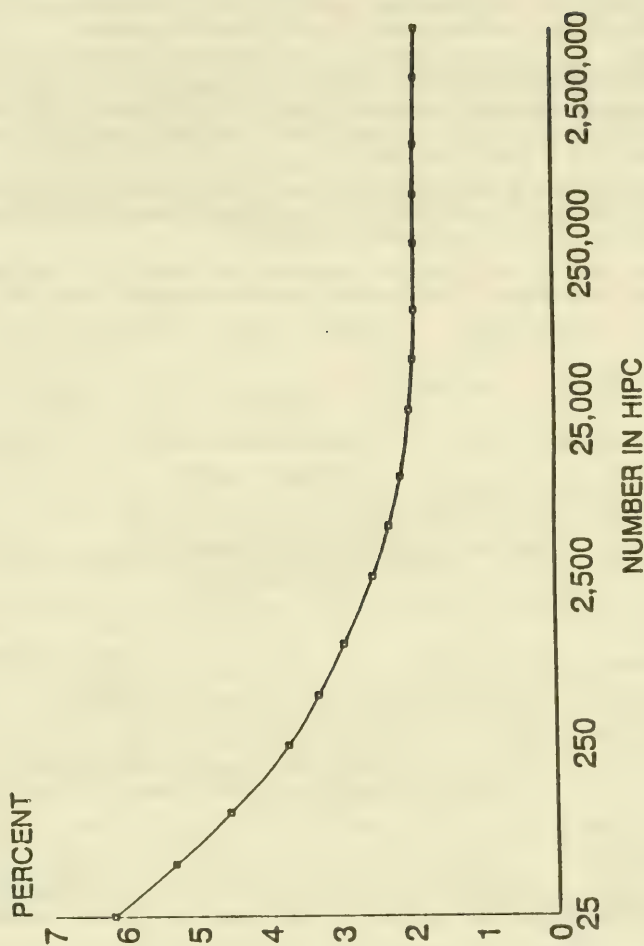
Table 2

ESTIMATED EXPENSE RATES FOR HIPC'S

<u>NUMBER OF PEOPLE</u>	<u>EXPENSE RATES (Pct.)</u>
25	6.17
50	5.31
100	4.54
250	3.72
500	3.30
1,000	2.94
2,500	2.53
5,000	2.30
10,000	2.14
25,000	2.02
50,000	1.96
100,000	1.94
250,000	1.94
500,000	1.93
1,000,000	1.92
2,500,000	1.91
5,000,000	1.90

Expense Rates are a Percent of Medical Costs Plus Expenses

Figure 2 EXPENSE RATES FOR HIPC'S



Percent of Medical Cost plus Expenses

CONCLUSIONS

The point of diminishing returns, for predictability of medical costs, levels out at about 50,000 insured people.

HIPC's will need to be very efficient to operate at a 2% expense level. In the beginning, HIPC setup costs will be high. The costs of implementing a tracking system for efficacy of doctors and treatments will also be high. A 2% expense level will probably not cover such a tracking system.

The size of the HIPC does not need to be extremely large to operate with relative cost efficiency. It appears that the HIPC costs level out around 25,000 covered participants.

Based on the statistical observations and calculations in this paper, the point of diminishing returns sets in below 50,000 lives.

Curriculum Vitae

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REVISED 08/93

Date of Appointment: 9/84

Birthdate: 01/19/36 **Birthplace:** Brainerd, Minnesota

Education:

B.A.	1958 U.C.L.A.
M.A.	1967 California State University at Los Angeles
F.S.A.	1977 Fellow - Society of Actuaries (S.O.A.)
F.C.A.	1993 Fellow - Conference of Consulting Actuaries (C.C.A.)

Experience:

1984-	Associate Professor, University of Connecticut
1980-84	Assistant Professor, University of Nebraska-Lincoln
1958-80	Assistant Actuary, Transamerica Occidental Life

Service:

1978-88	S.O.A. Part 3 Exam Committee-Chairman (1979)
1982-82	Chairman of S.O.A. Task Force to determine Numerical Analysis and Graduation Subjects
1982-91	S.O.A. Research Committee
1982-83	Chairman of S.O.A. Task Force to review Mathematical Graduation textbook
1984-	Faculty Advisor - UCONN Actuarial Club
1984-88	S.O.A. Part 5 Exam Committee (Vice-Chairman 1987-88)
1987-	Undergraduate Program Committee (UCONN)
1988-91	S.O.A. Demography Exam Committee
1991-92	S.O.A. Communications Policy Committee
1991-	Consultant to S.O.A. Exam Committee on Mathematical Graduation
1991-	Editorial Board ARCH
1992-	Referee T.S.A.
1992-	Faculty Associate - Center for Actuarial Studies (UCONN)

- 1993- Faculty Associate - NSF Grant for Computer Enhanced Calculus
 1992- Member - Committee on Committees (UCONN)
 1993- Member - Task-force for the Encouragement of Actuarial Literature (S.O.A.)

Memberships:

- 1961-79 Los Angeles Actuarial Club (President 1973-74)
 1962- Society of Actuaries (examinations required for membership)
 1963-79 Pacific States Actuarial Club
 1966- American Academy of Actuaries (examinations and professional experience required for membership)
 1980-84 Nebraska Actuarial Club
 1984- Actuaries Club of Hartford
 1986- Conference of Actuaries in Public Practice (now Conference of Consulting Actuaries) (examinations and professional experience required for fellowship)

Publications:

1. An Extension of Whittaker-Henderson Graduation. T.S.A. XXXIV, (1982) p. 329. (Refereed)
2. The Expectancy Discrepancy (with W. Luckner and M. Projector). P.C.A.P.P., 1984, p. 577. (Refereed)
3. Policy Reserves in Group Insurance (with P. Gerritson). T.S.A. XXXV, (1983) p.689. (Refereed)
4. An Application of Optimization to Life Insurance Planning (with J. Dauer, W. Luckner, and M. Osman). P.C.A.P.P. XXXVI, (1990). (Refereed)
5. A Generalization of Multidimensional Whittaker-Henderson Graduation Method. ARCH (1987), p.68. (Not Refereed)
6. Group Health Insurance Individual Stoploss Claim Study. P.C.A.P.P. XXXIX, (1989), p. 246. (Refereed)
7. Power Tail Distributions and Group Major Medical Expense Insurance Payments (with L. Lipsky). ARCH (1990), p. 121. (Not Refereed)
8. A Model for the Probability Distribution of Medical Expenses (with L. Lipsky). P.C.C.A. XXXXI. (Refereed)
9. Multidimensional Whittaker-Henderson Graduation with Constraints and Mixed Differences. T.S.A. XXXXV, to appear. (Refereed)
10. A Gompertz Age-Specific Mortality Rate Model of Toxicity from Short-Term Whole Body Exposure to Fission Neutrons in Rats (with P. Neafsey). Radiation Research, 133, 234-244, (1993), (Refereed)
11. A Mortality Kinetics Approach to Characterizing the Relative Biological Effectiveness of Short-Term Exposure to Fission Neutrons and γ Rays (with P. Neafsey). Radiation Research, to appear, (Refereed)
12. Pricing Aggregate Stoploss Insurance, 2/3 completed.
13. Mortality Effects of Radon Exposure in Sprague-Dawley Rats, 1/3 completed.

Note- Items 1 - 11 under publications are full length research articles.

Journals:

- ARCH - Actuarial Research Clearing House
 P.C.A.P.P. - Proceedings of the Conference of Actuaries in Public Practice (now Proceedings of the Conference of Consulting Actuaries - P.C.C.A.)
 T.S.A. - Transactions of the Society of Actuaries

The CHAIRMAN. I understand that is what the administration is attempting to do. My understanding of the alliance is that it is an administrative function, just like Medicare. Are you for abandoning Medicare?

Mr. LASZEWSKI. No, no.

The CHAIRMAN. That is a governmental structure. That is a Federal bureaucracy.

Mr. LASZEWSKI. I would suggest to you that in fact what the administration is talking about is creating a bureaucracy that in fact collects the premium and keeps eligibility straight. If, as a member of that alliance, you as a consumer found that adding a dependent to your health insurance coverage or something like that was fouled up, it had not been done, and you got to the doctor's office and they did not know who you were, who you would call is the Government alliance. The alliance keeps the books; it collects the premium on behalf of the employers, and it keeps the eligibility records. That is a very significant part of what insurance companies do now, and we can talk about where that can more efficiently be done, but it will be transferred under the plan to the health alliance.

The CHAIRMAN. Well, we will come back to that.

Ms. Cummings, I know there are some who are supporting the notion of the voluntary or competing health alliances. You are the one who has had the most relevant, real world experience since that is the way your program operates. So what is the additional administrative cost to your members as the price for a voluntary alliance?

Ms. CUMMINGS. Senator, there are additional market costs because we have to spend about \$3 million a year to attract people into the pool. About half of that is spent on direct sales staff, and the other half if spent on ads and billboards and things of that sort.

The other real concern in a voluntary environment is risk selection. People here have talked about the possibility of risk adjustment mechanisms which could correct for that. However, operating a risk adjustment mechanism in a market where there are voluntary purchasing pools and many, many, many insurance carriers would be logistically very difficult.

The CHAIRMAN. What happens when they go to the doctor, and there is some dispute about whether members of the family are covered? What is your interaction with the consumers?

Ms. CUMMINGS. Senator, we contract with a private company to collect our premium and handle enrollment for us, so the first call when there is a problem goes to that company. When there are continuing problems, we do see ourselves performing an ombudsman role, and we will get involved if we need to make an intervention in order to make sure that the person's situation is fixed.

The CHAIRMAN. Let me ask the whole panel—some of you may have differences as to the concept, but just to get your insight into this issue—there is substantial dispute over the question of the size of the alliances. Some of you have expressed views on this. The administration's plan would cut off at 5,000 and cover approximately 70 percent of the population. The alternative that is mentioned would cut it off at 100 employees and cover approximately 50 percent of the population.

Why does the 20 percent make much of a difference one way or the other? I would ask the whole panel to respond.

Ms. CUMMINGS. Senator, I am sorry, I did not understand—the 20 percent?

The CHAIRMAN. The difference is that with the cut-off at 5,000, you are covering 70 percent of the population—those are the large ones plus the Medicare, I guess, and you could still cover 70 percent. But if you cut it off at 100 employees, that represents 50 percent of all the businesses. And when you cut it off at 50, it represents about 93 percent. So if you cut it off at 100, that adds an additional 20 percent who would be outside the alliance. And I am just wondering, coming back to the question about the size of these alliances, that is what I am trying to get at and what your own view would be about it.

Ms. CUMMINGS. I do not have the magic number, but I do have an observation. We serve up to 50 employees. I think if your focus is an alliance that serves just small employers, my personal opinion is that you would need to go up to somewhere like 300, 400, in there, because there are definite market problems for small employers in that size.

However, I also note that there are real significant differences in health insurance premiums based on occupational rating, and the more that different kinds of employment groups are outside of the cut-off, the more cheaper occupations can get better rates, and the ones that cannot will be in the pool, which could make it more difficult for the pool to provide cost-effective coverage for the rest of the people in the pool.

The CHAIRMAN. Ms. Waxman.

Ms. WAXMAN. It would seem to me that, as the individual who worked for a company in that range that would be out, you would lose some of those advantages, that just as Ms. Cummings said, you would lose the advantage of being in a pool that is going to spread the risk. So if I were somebody in that employer situation, and I had some kind of condition that was more costly, I would have to bear that risk myself.

The other advantage, of course, is the portability. I would like to take advantage of the portability within the alliance regardless of the business that I am in, so that I can pick among the plans, and if I change from a smaller business to a somewhat larger business, I can still keep my health plan, and the only way I can do that is to be in the alliance.

The CHAIRMAN. Mr. Sullivan.

Mr. SULLIVAN. I think there is no magic number, either, but the larger the alliance gets, the closer it becomes to a purchasing monopoly or a single-payer system. The percentage of the market it represents would vary very much from one part of the country to the other.

The Jackson Hole feeling is that if you do not keep at least half the market in the hands of the private sector, you are going to lose the dynamism in the marketplace that is being driven now by private sector purchasing, by smart companies like Xerox and Digital and others, and by coalitions like the Memphis Business Group and the Orlando and Denver alliances as well.

So back to Bob Laszewski's point—let there be competition to see who best drives the market. Right now, the improvements in the market are being driven by private or voluntary groups. We are not opposed to the idea of an alliance that people have to be in below a certain level, but they should have some choice as well, and the key is to keep a dynamic alive on the purchasing side as well as the supply side.

The CHAIRMAN. Mr. Laszewski.

Mr. LASZEWSKI. Senator, I think it is important to again recognize the difference between two levels here. One is the marketplace at the approved health plan level, and the other is the health alliance. The issue of portability or of insurance cherry-picking rules or of risk adjustment formulas, whether it is the Clinton administration plan or the Chafee plan, those rules are enforced at the health plan level, and whether you have monopolistic or Government-run alliances or not, it does not matter; you have got those reforms. Now the question is do you merchandise those health plans only through the monopolistic alliance or various other things. And that goes to your question of how large should they be.

In my mind, first of all, if you go to a competitive model, you do not necessarily have to worry about that, because employers will make that choice. Second, in terms of the efficiency of the market and so forth, I think what will happen is even in a nonmonopolistic scenario, you will see the Government alliance and also competing alliances start to form up probably below 100 employees, because that is where you really get the efficiencies for the employer and for the individual.

Mr. SMEDSRUD. Let me make a couple of observations on the size. One of the problems with the threshold of 100 or the problem of the threshold of 5,000 is what happens in States such as North Carolina, for example, where the North Carolina Grange, which is a farm organization, has pooled 8,000 independent farmers into one plan. Now, they are not all working for one company, so whether that threshold is 100 or 5,000, they have indeed pooled themselves into one plan.

You will find that a lot in very, very small businesses. In Minnesota, the Employers' Association with 80 companies, most of those are 25 and 50 employees. Would you allow associations that band together to make their own cut-off if they are over 5,000? I think that is a very important question.

And again, in rural areas, the whole question of size of alliance probably needs to be considerably different than in urban areas. There are absolutely a lot of differences in scale in size from urban to rural, and I think writing specific rules is going to be problematic in that.

Mr. WICKS. I think the argument for having larger employers included, in addition to those that have already been made, is that it enhances choice for consumers. In middle-sized or large firms that are not in the alliance, the employer makes the choice of the health plan. I do not think that is consistent with what most people would prefer; they would like to have a broader range of choice. And second, it is not the way that competition is supposed to be driven. Consumers are supposed to make those choices, not employers.

The CHAIRMAN. Senator Mikulski.

Senator MIKULSKI. Thank you very much, Mr. Chairman.

Actually, we could spend a lot of time talking with each individual panel member. First of all, the panel should know—I think you heard me raise questions with Dr. Feder—that I have apprehensions about the health alliance, both in terms of its bureaucracy and then if it is solely market-driven.

Mr. Wicks, I think you gave one of the best arguments or best expositions on the merits of the health alliance, and I accept that. I want to go to you, Mr. Laszewski, because I think when you outlined your economic model, your behavioral model, and your political model, that is essentially the grid we need to focus on. Could you tell me now how you think the alliances as they are currently being proposed by the administration, do you think that they would be able to continue an alliance that would enhance and value mission-driven institutions, providers, and plans?

Mr. LASZEWSKI. In other words, would they be accountable and responsive to all the players in the economic community?

Senator MIKULSKI. Yes, because you see, I really worry about the Wal-Mart model. Do you want me to tell you why? Why don't we do that. I am going to just substitute discount store medicine, or health care, not just medicine.

Mr. LASZEWSKI. All right.

Senator MIKULSKI. Wherever the discount store comes in, it often has a disastrous effect on other businesses. Main Street often closes down. The furniture store that has been open for years; the dress shop, serving large sizes as well as petites, goes by the wayside; where you had personal relationships, and you were known by your record with them, that goes by the wayside, and you go into an anonymous, bureaucratic store, no matter how attractively designed and how attractive the cost.

My concern is that that is exactly what we could end up with, discount store medicine without the kind of pluralistic approach that we have, either by religious preference, veterans, because of the culture involved in it, or whatever.

Mr. LASZEWSKI. Yes, I think that is an excellent point, and let me again stress the point that I made earlier. What we are talking about in health alliances is the merchandising, the sales function of the health plan. You are really onto something when you say we cannot have Wal-Mart medicine, we cannot have second-rate medicine just to contain cost.

Senator MIKULSKI. I did not call it "second-rate." I would just call it destructive to other—

Mr. LASZEWSKI. To other businesses. And the point is that it is the health plans that are the framework through which care is delivered. It is the health plan, not the health alliance.

What we are really debating when we are debating health alliances is the distribution system to sell it to the consumer. So really, what the debate here is about is what is the most efficient way to distribute or sell these health insurance plans to the consumer.

Now, if we went to the exclusive health alliance at 5,000 employees, to continue your analogy, the local businesses, the little guys out there, the shopkeepers, are by law taken out of the market. They are gone. You do not have Wal-Mart; you have the U.S. Gov-

ernment takes over retailing; the health alliances take over retailing. The little guy is gone.

What we also are recognizing, and it sort of goes back to Senator Kennedy's analogy about supermarkets, which is probably an even better one, is that I think people are coming to the conclusion that we have got to distribute insurance plans, not health care, but insurance plans, more through the supermarket concept where you have much larger pools, and the expenses can be less, for example. It is just like going from the mom-and-pop store on the corner on up to the supermarket.

What we are talking about, using Senator Kennedy's analogy, is saying to the Government: You will run the only supermarket in town, or at least for 70, 80 percent of the market. We are going to the American people and saying: You are going to buy your health insurance at this supermarket now. By the way, there is one supermarket, and the Government runs it. That would be like going to people in Lawrence and saying there is one supermarket, and the Government runs it.

What I am suggesting is, okay, set up the Government supermarket as a competitive catalyst; that makes sense to me. But at the same time, let the little mom-and-pop store on the corner compete with the supermarket, and let me set up a supermarket, because I think I can beat the Government's supermarket. The Government's supermarket might have 150 plans, and the catalog might be kind of confusing for me to understand, and maybe I do not like the way it handles my service problems when you lose my enrollment card. And maybe there is another supermarket over there, run by an entrepreneur, that has boiled it down to only seven plans that I have to choose from. I have the range of choices, but gee, this is a lot simpler, and their communication materials are a lot easier to understand, and when I call their phone number to say my eligibility got lost, they are much more sensitive.

Senator MIKULSKI. I understand that. How would you propose that be accomplished?

Mr. LASZEWSKI. It can be accomplished by allowing the Government, or the regional authorities, to set up a buying pool, but not prohibit others to set up a buying pool and not prohibit consumers from purchasing outside those pools if they wish. It is that simple.

At the same time, we have underwriting reform, portability amongst all health plans, end the cherry-picking kinds of issues. What we have got to do is to drive the market so that when a consumer buys health insurance, whether through his employer or directly, he is not confused by different and confusing benefit plans, by pre-existing condition provisions, and all those kinds of things, and what they are focusing on is where do I get access to what I think are the best providers for the best price. All of those things can be accomplished without turning the supermarkets over to the Government.

Mr. SULLIVAN. Senator, could I respond to your point as well?

Senator MIKULSKI. Yes. You see where we are trying to head, and all ideas are welcome.

Mr. SULLIVAN. I appreciate that very much, and I think your concern is an important one. I would like to say that some of the coalitions that I represent and some large national employers are pretty

far down the road to measuring quality as it is delivered in the health care system, something we have not talked about much today. But our strategy is called "value-based purchasing." We are way past the point of seeking discounts, at least in the enlightened employer community, because you know that is cost-shifting, and it is not reducing costs, and it does endanger quality—just what you are concerned about.

It is employers right now who are helping to lead the way, working with progressive provider organizations, to develop these systems in many of the communities I have mentioned that measure quality, that make sure that costs are getting reduced in a way that is getting rid of unnecessary utilization, but is not jeopardizing the quality of care being delivered. That is part of the dynamic that I referred to when I responded to Senator Kennedy's question about why it does not matter what percent of the market is represented by the single alliance.

We believe that we are in a position right now—we being the private purchasers—to really help the consumer in this process of figuring out and seeking out quality in the medical marketplace. Perhaps further down the road, we will have a marketplace where our role is less needed, but at the moment I think it is a critical one, and that is why we have to stay involved, aside from the fact that we are also spending a lot of the money in paying for health care.

Senator MIKULSKI. I know the afternoon is ticking on, but Mr. Sullivan, perhaps you could tell me, in this framework that you are advocating, would you ensure universal access, retain a guaranteed benefit package with these competitive alliances?

Mr. SULLIVAN. Oh, yes. The rules would be the same for everybody with respect to having a package of benefits that people are entitled to across plans, since you do not want the competition on that basis. And we have our own approach to universal access. It is not that the portability issue that came up earlier will be taken care of by dealing with the universal access question. There are a couple of different ways to do that, but yes indeed, it is part of the plan.

Senator MIKULSKI. Jeff, I know you wanted to comment, and then Ms. Cummings, and my time is then expired.

Mr. SMEDSRUD. I would echo Sean's view. In rural areas, we can reform and change health care and have access to everybody. We can change the marketplace. We are starting to do that in a number of States, Minnesota being one of them, Florida being another, and Iowa is about to.

You can do all that. The problem with the one or two alliances in a State—in the State of Colorado, one alliance—is that it does not allow rural people the opportunity to build their own solutions, and it puts tremendous emphasis on a few people in that State to decide the best way to find those efficiencies.

If rural people can find those same efficiencies and do it better and create jobs at the local level, which is what we need to do in rural America, then they ought to be allowed to do that—as long as you have access, as long as you have a level playing field, as long as you have standard benefits.

Personally, we would like to see a little broader definition of what the benefits ought to be, so there is maybe a little bit more

choice in benefits, but I think we can accomplish those, and there are a number of instruments, some blunt, some not so blunt, to accomplish that.

Senator MIKULSKI. Thank you.

Ms. CUMMINGS. Senator, I just want to say that I think a view of health alliance is that it is more than a distribution system, but the way by which competition can manifest itself. When you have standard benefit plan designs, and what you are looking at is making judgments about quality and price, and that is what the competition is about, that is where you can really have competition that is useful to the consumer.

I am fearful that in a voluntary environment, what the competition will remain to be about, even in a reformed environment—and we see this now in California, and I think you would continue to see it under the President's stronger reforms—is competition to avoid risk. Even in a community-rated system, young people are always going to be the most desirable business. When you have a voluntary market, people will find ways to attract low-risk business into places not the pool, and the pool will have increasingly higher prices that will have to be passed on to pool members.

Mr. LASZEWSKI. Can I respond to that point, because I think it is an important one. If we had monopolistic alliances—let us say one for the Boston metropolitan area—and I wanted to cherry-pick, even though you have one monopolistic alliance, what I would do is I would go out and only sign up hospitals for my health plan that were in the western suburbs, away from the expensive teaching hospitals. If I thought people downtown were sicker, I would sign up my doctors in the western suburbs. I would put my health plan in the catalog. It would be approved. It would select in the sense that only somebody who lived in the western suburbs, near the lower-cost hospitals and maybe healthier population, would choose.

There is an example of how you can game the system in a monopolistic alliance. The way to get around that is the risk adjustment formula, so that if I did that, I would have to pay into the pool for those plans that were operating, say, downtown. You can have that risk adjustment formula in a monopolistic or nonmonopolistic marketplace.

Senator MIKULSKI. Thank you, Mr. Chairman. As you can see, this has probably provoked more discussion than some of the other discussions we have had on this issue. I think it is something that I am sure, once the legislation comes up, we will revisit.

Although I did not ask questions of everyone, I really have benefited from this and look forward to further conversation with you.

The CHAIRMAN. Thank you very much.

[Additional material follows:]

ADDITIONAL MATERIAL

UNITED STATES SENATE

COMMITTEE ON LABOR AND HUMAN RESOURCES,
WASHINGTON, DC 20510-6300,
October 22, 1993.

Mrs. Hillary Rodham Clinton,
The White House,
1600 Pennsylvania Ave., NW,
Washington, DC 20500.

DEAR HILLARY: I understand that a new option has come under serious consideration in the last few days for funding expanded public health service activities and possibly academic health centers as well. This option would create a separate "receipt" account for this purpose, which would be financed by a premium surcharge or some other dedicated funding source. Because it is a receipt account, it would be outside the discretionary caps.

You asked me to let you know if there were any aspects of the President's program that would distort normal jurisdiction. For many years, all Public Health Service Act programs, including community and migrant health centers, nurse training programs, Centers for Disease Control programs, and the National Institutes of Health, among others, have been the exclusive responsibility of the Labor and Human Resources Committee.

Standing alone, the new public health funding would unquestionably be within the jurisdiction of the Committee on Labor and Human Resources. But the receipt account option would shift it to the Finance Committee. The Senate Parliamentarian has informed us that the account would be considered a trust fund for jurisdictional purposes, and the Finance Committee has clear jurisdiction over trust funds used for health care.

I also understand that the receipt account option would create a sixty vote point of order for the legislation under the Budget Act, because it would be viewed as an attempt to circumvent the discretionary spending caps.

I would like to propose an alternative approach to achieve the Administration's goals without creating jurisdictional problems or violating the Budget Act. Under this approach, Public Health Service funding would be treated as capped, mandatory spending. Such spending is outside the discretionary caps but is carefully controlled and limited by the authorization amounts. There are already ten such programs in existence (list attached).

As I understand it, the rationale for the receipt account option is the importance of avoiding the appearance of creating any new open-ended entitlements. But that objective can just as easily be achieved under the approach I have proposed.

Because the amount of capped, mandatory spending is specified in the law itself, it cannot be higher than the law allows. It does not change with the economy, number of beneficiaries, or any other factor. Thus, it has nothing in common with the open-ended entitlements. None of the concerns involving entitlements has ever been raised, to my knowledge, about the existing capped mandatory spending programs. Indeed, the only major difference between a capped mandatory program and a regular appropriated program is that the authorizing committees, rather than the appropriations committees, control the funding level.

I hope you will give serious consideration to the alternative I have proposed, which is of great importance to me. Many thanks for considering this request, and I look forward to next week's unveiling.

Sincerely,

EDWARD M. KENNEDY.

LIST OF CAPPED ENTITLEMENTS/MANDATORY SPENDING AUTHORITIES

1. OBRA 81: Social Services Block Grant (Title XX of the Social Security Act)
2. OBRA 86: Section 9414: Medicaid Respite Demonstration
3. OBRA 89: Section 6407: (Medicaid) Demonstration Projects . . .

OBRA 90:

4. Section 4711: Home and Community Care for Functionally Disabled Elderly Individuals (Section 1905(a)(23) of the Social Security Act)
5. Section 4712: Community Supported Living Arrangements Services (Section 1905(a)(24) of the Social Security Act)

6. Section 4745: Demonstration Program to Study the Effect of Allowing States to Extend Medicaid Coverage to Certain Low-Income Families . . .

7. Section 4747: Demonstration Project to Provide Medicaid Coverage for HIV-Positive Individuals

8. Section 5081: Grants to States for Child Care (Section 402(i) of the Social Security Act)

Newly Enacted in OBRA 93:

9. Section 13761: Social Services in Empowerment Zones and Enterprise Communities

10. Section 13711: Family Preservation and Support Services

STATEMENT OF MENNONITE MUTUAL AID ON HEALTH CARE REFORM

INTRODUCTION

This statement explains a unique organization in health insurance—Mennonite Mutual Aid (MMA).

MMA is an insurer of Mennonites and members of other historic Anabaptist churches. It is operated by the Mennonite Church under traditional church beliefs concerning stewardship and mutual aid. It provides Mennonites with comprehensive, high quality major medical plans, emphasizing cost containment through managed care.

MMA commends the Congress and the Clinton Administration for undertaking reform of the health care system. Our organization began calling for reform as early as 1988, and we welcome the current national debate. We want to work with the Congress to enact universal coverage.

Our particular expertise is in rural areas where most Mennonites live. We are concerned that large, compulsory regional alliances will become a barrier between Mennonites and the MMA health plans. We respectfully request that Congress permit Mennonites to continue to have access to MMA health coverage without compulsory participation in regional alliances.

HEALTH INSURANCE AS MUTUAL AID TO THE COMMUNITY OF FAITH

MMA provides health insurance coverage only to Mennonites and members of other historic Anabaptist churches.

MMA bears all of the risk of insuring its members. Like other health insurers, MMA is fully regulated by state insurance departments. We do not purchase coverage from a commercial insurer. MMA is an insurer of Mennonites, operated by Mennonites with a 400-year old tradition of mutual aid in the community of faith.

MMA insurance is provided to Mennonites in ways consistent with Mennonite beliefs. For example, we help low-income members with premium payments, promotes values that help members make end of life decisions, and actively support healthy lifestyles.

Mennonites believe we are stewards of our health, one of God's great gifts to humankind. In applying the Anabaptist concept of mutual aid to health care, MMA offers members benefits not provided by other insurers such as:

Special help for health costs not covered under the policy.

Aid for uninsured Mennonites who unexpectedly face high medical bills.

Grants for congregations reaching out to their local communities through special programs.

Premium assistance for members with dependents who have physical or mental disabilities.

Assistance for members faced with high adoption expenses.

AIDS education materials.

Nurse in the Congregation (a health ministry program for Mennonite churches).

Educational materials on medical ethics and advance medical directives.

Special courses promoting healthy lifestyles through wellness activities.

MMA COVERAGE AND OPERATIONS

MMA offers comprehensive, high quality major medical plans to Mennonites, emphasizing cost containment through managed care. This is accomplished through: direct contracting with hospitals and special service organizations, Preferred Provider Organization (PPO) networks, precertification, large claims management, reasonable and customary charge evaluation, and challenging both physician and hospital prices on a claim-by-claim basis, and steering members to selected efficient providers where a formal PPO/HMO arrangements do not exist.

The daily operation of MMA reflects Mennonite theology:

MMA is accountable to the Mennonite Church. Its volunteer, unpaid board of directors is elected by the Mennonite membership. Salaries and benefits paid to officers are modest.

Risks underwritten by MMA are broader than those accepted by commercial insurers.

Moral judgments reflecting Mennonite beliefs govern and restrict MMA's investments. We avoid investments in defense, alcohol, tobacco, and gambling industries. Instead, we invest in businesses that promote a better quality of life such as housing, food, transportation, and utilities.

MMA provides churches with first-mortgage loans at reasonable interest rates to encourage growth.

Overhead costs are kept low in accordance with Mennonite beliefs in stewardship.

MMA and Health Care Reform

MMA congratulates the Administration and the Congress for focusing on reforming the U.S. health care system. We would like to work with Congress in a positive, supportive, and cooperative way to help devise a national health system that will work. Our particular concern and expertise is with rural areas where most Mennonites live.

Compulsory alliances

We are highly skeptical that the concept of large, impersonal regional alliances will work in rural areas. The Mennonite community would not find this an attractive nor hospitable environment. Our theological and historic experience for over 400 years has centered upon mutual aid in the community of faith. Our members do not want to be forced to join a large alliance with many people who do not share our beliefs and values. If this were enacted, many Mennonites in rural areas would not participate; and if they did, the intervening bureaucracy would become a barrier to Mennonites connecting with the MMA health plan.

In any legislation that Congress passes, we respectfully request that Mennonites be permitted to continue their MMA health plan for the community of faith without compulsory participation in large regional alliances.

Religion rather than employment bonds Mennonites to MMA

In many of the proposals for health reform, including the Clinton Administration's, exceptions are created only for large groups in an employment relationship. The Administration, for example, would let multistate employers with more than 5,000 employees opt out of the compulsory regional alliances. Those who opt out become subject to regulation by the Department of Labor under ERISA.

MMA is a multistate organization with 20,000 members. We are subject to regulation as an insurer in every state where we transact business. We respectfully request the ability to opt out of the regional health alliances on the basis of the strong ties of religious faith between our members—and MMA. Of course MMA would remain subject to state insurance regulation and any other requirements Congress imposes for health insurance coverage.

Choice in the context of reform

MMA believes Mennonites and members of other historic Anabaptist churches should have the freedom to purchase health plans from MMA within the framework of health care reform. Our hope is to give our members the opportunity to purchase a health plan from MMA if they choose to do so which will allow us to continue to pursue the church's mission of mutual aid and stewardship.



Hampden District Medical Society

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TEL. 736-0681

October 25, 1993

The Honorable Edward M. Kennedy
The United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

As President of the Hampden District Medical Society, I appreciate the opportunity to present a physician's viewpoint of health care reform in the United States.

Physicians, as citizens of our society, as well as providers, applaud the movement to bring healthcare to center stage in order to improve the system in terms of prevention, delivery and efficiency. As physicians we agree that everyone should have access to appropriate health care. We recognize that the costs of healthcare in any model, requires some sort of "insurance" to facilitate access and delivery. We believe that "insurance" should be universally available regardless of job mobility, employment status or pre-existing condition.

Physicians have many roles in our system--some are teachers, some research new tools or theories to improve our science, some administrate to try to improve efficiency and many practice, actually deliver the care. This latter is the final common pathway of the whole system and our reason for being. Our present system is rife with features that interfere with that step of the physician delivering his or her best care to the patient. These features have in common the addition of layers of review, paperwork, telephone messages up and down organizational frameworks that purportedly contain costs (they do not!) while "assuring quality" (always a policy afterthought). I would submit there are substantial savings to be had by minimizing administrative micromanagement and by utilizing the jobs so saved on the prevention side of our system.

I would also submit that an increased societal will to practice reasonable disease prevention strategies (minimizing tobacco, drug and alcohol use, safe sexual practices, maternity and child preventive care, violence control) will produce far greater benefits than our emphasis on healthcare delivery. Further failures of social policy, for example, infant mortality rates are inappropriately equated with failure of our healthcare delivery system.

I believe physicians would generally support reform that addresses these issues while preserving the many advantages of our system, most importantly the doctor patient relationship, but also the outstanding research and educational aspects of our system which must be allowed the academic freedom to respond to our society's stated needs.

Physicians view with alarm reforms that create more and more bureaucratic burden which either fails to improve, or actually impedes, patient care. Unfortunately our experience with government (federal or state) models does little to assuage that fear. Parenthetically single payer systems elsewhere haven't really altered the course of health cost as much as delayed it.

I would re-emphasize that physicians applaud the goals of reform and would suggest that as the model for our health care delivery systems is formed and implemented, the knowledge and experience of the people who actually do the work - physicians, nurses, therapists of different sorts - will be invaluable to help produce a system all Americans can be proud of.

Again, thank you for this opportunity.

Sincerely,

Francis D. Horrigan M.D.

Francis D. Horrigan, M.D.
President
Hampden District Medical Society

HEALTH PLAN PURCHASING COOPERATIVES (HPPCs) AND REFORM OF THE SMALL GROUP HEALTH INSURANCE MARKET

Alain C. Enthoven and Sara J. Singer

I. Special Problems in the Small Group Market

Small employment groups (say of 100 employees or less) share with large groups serious problems in purchasing health care: high and rapidly increasing costs, and a health care system lacking in accountability for quality or resource use. In addition, small groups suffer from many problems of their own:

- Small employers are too small to spread the risks of high medical costs. Hence, because of underwriting and experience-rating, there is wide variation in premiums paid (10-fold and more), premiums are unstable and can increase sharply with illness, and access can be denied as individual or whole groups are cut off from coverage as the result of a costly medical episode.
- Small employers are too small to achieve economies of scale in administration. The carrier's administrative expense, by one estimate, reaches 40 percent of claims in the case of groups of one to four, compared to under 5 percent for groups over 10,000 [1]. Of course, these higher carrier costs must be passed on to small group purchasers. Estimates of the employer's costs to manage its side of the transaction are not available, but they must be substantial unless and to the extent that the employer simply chooses to do a poor job of it, in which case costs of a poor quality choice are bound to emerge in other ways. The costs include time of the employer's executives plus consultants, agents and brokers. Both health insurance and health care are very complex markets in which substantial expertise and experience are needed to purchase wisely and effectively. It is very costly for a small employment group to acquire such expertise. As health care is not a small employer's core business, most do not make the necessary investment and view the acquisition of health benefits as a nuisance.

Similarly, it is very costly for health care financing and delivery plans ("health plans") to enter this market of small groups because to do so, they must incur the costs of making a sale and contracting with each small group, to sign up a relatively small number of people per group.

- Small employers are too small to manage competition among Accountable Health Plans (AHPs), the process needed to drive down costs (see below).
- Small employers are too small to offer choices of health plan to individual subscribers. If an HMO wants to be offered as a choice in a small group, the traditional indemnity insurer will usually decline to participate, arguing (with some accuracy) that this would split the group, raise administrative costs, and leave the insurer with the poor risks. Thus, small groups usually offer their members a single carrier. In a world of managed care, in which there are contractual links between carriers and doctors, changing health plan means changing doctor. To persuade a whole group of people to switch from one health plan to another - which is likely to mean changing doctors - a high level of agreement is required. This can make it very difficult for a managed health care plan seeking to serve the group to win the business, even if it offers a substantial price reduction. This makes demand for health plans in this market quite inelastic with respect to price. (See "Create Price-Elastic Demand" below). Inelastic demand means that a company's sole carrier can raise prices substantially before they become high enough for people to consider switching. This attenuates or destroys the incentive to reduce price normally created by competition.

These problems doubtless contribute to the fact that the percentage of employees without employment-based health insurance is much higher in small groups than in large groups. Solutions to these difficult dilemmas are possible. To understand these recommendations for resolving the problems of small groups, the reader must first understand the theory behind and the context within which we envision such reforms.

II. Managed Competition of Accountable Health Plans (AHPs) [2]

Managed competition is a purchaser strategy designed to reward with more subscribers and revenues those AHPs that do the best job of improving quality and cutting cost. Thus, managed competition seeks to create accountability for quality and cost, and powerful incentives for health care organizations to reduce cost. The insurance industry has proposed an alternative strategy which is attached as Appendix A for the readers' information.

AHPs explained. An AHP is an integrated financing and delivery organization that covers a standard package of uniform effective health benefits, that is publicly accountable for health outcomes and per capita cost. AHPs are paid in the aggregate, on the basis of per capita periodic payments set in advance. They do not get more revenue by doing more procedures.

If such organizations function in a framework of value-for-money competition (see below), they will face powerful incentives to force the providers in their network to improve quality and reduce cost. There is much such organizations can do to pursue these objectives, including:

- aligning the incentives of providers and the interests of patients in high quality economical care;
- selecting providers for quality and efficient practice patterns;
- creating outcomes measurement systems, studying variations in practice patterns from the point of view of outcomes and resource use, and adopting cost-effective practices;
- matching resources used to the needs of the population served. In particular, matching numbers and types of doctors to the needs of the population served so that primary care will be accessible, and so that specialists will have full schedules and a referral system that assures they see just the patients they were trained to see;
- emphasizing primary care, prevention, and management of chronic conditions to prevent their becoming costly acute cases;
- emphasizing less costly personnel where appropriate: primary care physicians supported by specialists in lieu of specialists as a first resort, nurse practitioners in lieu of physicians;
- allocating resources efficiently across the total spectrum of care, including home care, outpatient surgery, etc.;
- regionalizing concentration of costly specialized services such as open-heart surgery so that physicians and facilities can gain expertise and thereby reduce costs and mortality rates;
- pursuing continuous quality improvement;
- establishing careful technology assessment and a rational response to it.

The Role of Sponsors in Managing Competition. Managed competition seeks to create a framework of incentives for AHPs to improve quality while reducing cost. Managed competition requires the existence of a sponsor that creates and seeks to perfect the market. A sponsor may be a large employer, an entity acting on behalf of small employers' (see HPFCs below), the state or federal government, or some combination of the above. Sponsors do the following:

Create price-elastic demand. I.e., create a condition in which many people would be willing to switch from Plan A to Plan B in order to save even a small dollar amount per month in premium.

- Organize and conduct a fixed single annual enrollment through a single point and time of entry, with information presented on cost, quality and participating physicians in such a manner as to facilitate a side-by-side comparison and convenient choice. Individuals will be, on the basis of information provided to them, at least as well-informed and capable of making decisions about cost-effective care as are small employers currently.

- Require individual subscribers to bear full responsibility for the differences in premiums among the plans they chose. To make this happen, a single employer sponsor must have a defined-contribution policy with contributions not to exceed the price of the low-priced plan. Given such a policy, an employer would be indifferent to the plan chosen by an employee.

A multi employer sponsor needs to set rules to make individuals cost-conscious. Federal and state governments need to do their part by limiting the amount of employer/employee contribution that can be tax-free to the employee. Such a policy would make individuals choosing health plans fully conscious of the differences in price.

- Standardize the benefit package to facilitate value-for-money comparisons. This function may be most appropriate at the federal or state level.
- Present comparative quality information in an accessible form to facilitate informed decision making.
- Assure a full range of choice of plan so that individuals can choose the plan that is right for them and so demand will be as elastic as possible. The widest range of employee choice may not be practical for small employers as sponsors.
- Each health plan sets a single price for all subscribers in a rating category (i.e., plan A sets one price for all purchasers of its individual coverage which may, of course, be different from plan B's price).

Minimize the incentive and ability of health plans to select risks. Currently, health plans attempt to identify potentially high- and low-cost users of medical care and to avoid and attract them respectively.

- Have a single point and time of entry (because direct marketing between health plans and subscribers creates opportunities to select risks).
- Standardize the benefit package to prevent its use by health plans to select risks.
- Risk adjust premiums (i.e., "tax" plans that get favorable selection, compensate those that get unfavorable selection) to allow consumers to choose plans based upon risk neutral premiums and to permit AHPs to compete on a level playing field. Under risk adjustment, centers of excellence and forms of AHP attractive to less healthy individuals will not be penalized. Such a mechanism would eliminate the reward and incentive for AHPs to try to select risks.
- Monitor voluntary disenrollments for risk-selecting behavior.
- Set standards for access to specialty and tertiary care so that access cannot be used to select risks.

Set rules to assure equitable coverage of all persons in the sponsored group.

- Health plans accept all who enroll through the process.
- Health plans guarantee continuity of coverage through the contract year.
- No exclusion of preexisting conditions.
- Community rating within the sponsored group.

III. Health Plan Purchasing Cooperatives

The Health Plan Purchasing Cooperative (HPPC) is a pooled purchasing arrangement intended not only to spread risk and achieve economies of scale for small groups, but also to give access to members of small groups to the competitive process available to large groups to drive improvements in quality, reductions in cost. The HPPC is the institution that performs the "market creating" and "perfecting" functions of a sponsor in the case of small groups too small to perform these functions for themselves. See Appendix B for an example of how one HPPC, the California Public Employees' Retirement System (CalPERS), works.

With respect to HPPCs, small groups should include businesses with 100 employees or fewer, including self-employed persons. These individuals and their dependents account for between 30 and 55 percent of the nation's population, depending on the source and definition (i.e., firm or establishment), a substantial chunk of the market no matter how you calculate it.

Estimates as low as 30 percent are based on nationwide firms rather than locally-based establishments. This distinction is important. While a firm may employ thousands of people nationwide, many of its offices are locally based, with much smaller numbers of employees. Employers and employees purchase health care locally. If employees work in a small establishment, regardless of the size of the firm overall, they suffer the same problems as small groups. Therefore, employees who work in establishments with 100 employees or fewer, outside the headquarters of a firm should also purchase coverage through a HPPC. In fact, the Clinton draft proposal for health care reform would enable large employers to purchase health coverage for their employees in small establishments through the regional Health Alliance (i.e. Clinton's name for a HPPC). Inclusion of these employees and their dependents would make the 55 percent number a more reasonable estimate of the population that would be served by HPPCs. To ensure pluralism on the demand side of the market, inclusion of firms larger than 100 employees is not recommended.

What the HPPC Does And Why or Whether a HPPC Is Needed to Do It.

First, the HPPC spreads risk over its entire sponsored population: each health plan over its own enrolled members (all of whom pay the same premium for the same coverage from any given plan), and, by risk adjustment, the HPPC spreads the risk among health plans.

Risk spreading could be done by, for example, the state requiring all health plans to community rate in the small group market, running a risk-adjustment mechanism (as New York is doing), combined with "guaranteed issue" so that health plans can't hide from poor risk groups. To that extent, the state would be performing HPPC functions. The HPPC pulls these and other functions together and "guarantees" the guaranteed issue by creating a single point and time of entry, the fixed annual enrollment process.

Second, the HPPC achieves economies of scale in administration. For example, Kaiser Permanente of Northern California and CalPERS sign one annual contract to cover over 150,000 lives. The HPPC also serves as a single efficient clearing house for enrollment information and money. Suppose, for example, that there are in an area, 30,000 small employers and 12 health plans. Without a HPPC, there are 30,000 times 12 flows of transactions if every employer deals with all health plans. (Of course, in practice, small employers deal with only one or two carriers, which limits competition and consumer choice.) With a HPPC, all deal directly with the HPPC, reducing the number of flows of transactions to 30,000 plus 12. The HPPC thus greatly reduces the cost of marketing and market entry.

The HPPC also sets and monitors compliance with rules governing employer behavior, such as underwriting and employer contribution (there is a need for a rule regarding minimum and maximum employer contributions). It would be much more economical if one HPPC, rather than all 12 health plans, were to monitor the behavior of each employer.

Third, the HPPC "manages competition" in the sense explained above, including running the annual enrollment process, standardizing the benefit package (unless state or federal government does that), publishing comparative information on price and quality in a form accessible to and relevant for local purchasers, and does the risk adjustment (unless a state agency does it).

Fourth, the HPPC should be a "demand side" advocate, representing the interests of employer and employees and other covered people. It should actively monitor what is happening, and devise additional procompetitive market-perfecting strategies if health plan or employer behavior makes that necessary. HPPCs should not have the power to refuse to deal with a certified AHP. Initial certification and recertification of AHPs should be done at the federal or state level. Certification will assure, among other things, that AHPs will have adequate provider networks and financial resources. HPPCs should not limit individual choice of plan to a particular form of delivery system (i.e., HMO, PPO, or indemnity). For most individuals, choices through the HPPC will allow them to continue to see the physician of their choice.

Any other agency that performs these functions is merely a HPPC by another name.

However, the HPPC is a "price taker," not a "price maker." It does not negotiate prices in the sense that it refuses to deal if the price is not right. That is for price-conscious consumers to judge. Writers like to explain HPPCs as exercising the "clout" or "bargaining power" of a large employer. This is inappropriate if it refers to price setting. "Clout" and "bargaining power" are only relevant in the sense of achievement of economies of scale and enforcement of adherence to rules. (For example, a HPPC could initiate decertification proceedings of a health plan because of the insurer's persistent refusal to play by the rules regarding risk selection.)

Assuming that a HPPC will cover a large percentage of its market, if it had the power to set prices, it would not need to engage in negotiations. Rather, its market power would enable it to set rates and dictate them to AIPs. When this happens the HPPC would likely set the same rates for all AIPs, and once those rates are set there would be no opportunity for consumer choice based upon cost. There would be no market forces at the consumer level and thus no price elastic demand. Moreover, giving HPPCs the power to negotiate rates plays into the hands of those who favor global budgets enforced by HPPCs.

Having said that, HPPCs should still save employers money. Health plans should be able to pass on savings from reduced marketing and administrative expenses. Given employers' defined contribution policies, health plans will want to offer lower prices (and seek new efficiencies by which to do so) because they will be rewarded for lowering their price with more enrollees.

There is concern that HPPCs would be "a new layer of bureaucracy." Rather, they would consolidate and/or replace a great deal of ineffective existing bureaucracy, including costly agents and brokers. Small employers such as the Mosquito Abatement District of Antelope Valley, with two employees, which belongs to CalPERS, gets the services of a first-rate health benefits management organization for one-half of one percent of premium - probably around \$30 per year. Because of the limited functions of the HPPCs envisioned here, they would be relatively easy to establish and would not interfere with the establishment of other reforms.

Finally, HPPCs should not be seen as a regulatory agency, controlling either prices or allocation of capital. Price controls do not work to reduce costs to consumers. Given a spending limit, participants would spend the maximum allowed to ensure future spending rights and would apply political pressure to get the maximum increased. Furthermore, when capital flows through agencies controlled by politicians, the allocation of capital turns into wasteful "pork barrel," allocated to serve the electoral needs of politicians rather than the needs of patients.

IV. The Problem With Voluntary HPPCs

One popular response to the HPPC idea is to create them but to make membership voluntary. It would be so much more attractive to offer this wonderful service to those employers who want it while not coercing those who don't. California and Florida have enacted voluntary HPPCs.

The trouble with that idea - and the reasons that voluntary HPPCs have not appeared spontaneously in the free market across America - is the wide variation in health risks and cost across small employment groups. Those groups with high premiums because of bad medical experience, especially those who cannot even buy coverage in the private market, are delighted to join a pool where their costs will be averaged with those of others with lower costs. But, of course, the low cost groups would prefer not to be pooled (until someone in their group gets sick) because they can get better premiums on their own. Thus, the likelihood is that the poor risks will join, the good risks will not, and the pooled premiums will be caught up in a spiral of adverse selection. Current risk adjustment mechanisms do not compensate across pools but only within pools and would therefore not prevent this phenomenon. These considerations would argue that the HPPC cannot be purely voluntary; it must be exclusive. There has to be some powerful incentive to make the good risks choose to be pooled, which we believe is in their own long run best interest.

There are several ways this might be done. One is simply to outlaw the purchase and sale of health insurance in small groups outside the HPPC. Another - proposed by the Jackson Hole Group - is to condition the federal tax exclusion for employer contributions in small groups on purchasing through a HPPC. Another might be to tax coverage outside the HPPC and use the proceeds to subsidize coverage inside the HPPC.

Our experience with the Clinton Administration's treatment of the HPPC idea and their preference for one regulatory agency with monopsony power (i.e., a single purchaser) leads us to consider additional mechanisms for preserving pluralism on the demand side and allowing for innovation and experimentation, without creating a ready vehicle for state monopsony power.

One possibility worth further consideration would be:

- All health plans serving the small group market would community rate a standard benefit package.
- There would be a statewide risk adjustment mechanism along the lines of the one New York has created for its small group market.
- Voluntary HPPCs, even multiple competing HPPCs in the same territory (as originally proposed by the Bush Administration, though without community rating), to offer small employers economies of scale in administration and to facilitate multiple choice at the individual subscriber level. HPPCs would practice open enrollment. They would not be allowed to negotiate rates. They would compete on customer service and efficiency of operation. Given the uncertainties as to how such an idea would work in practice, some experimentation seems desirable.

V. Why Individual Choice of the Full Range of Participating Plans

A point of controversy in the 1992 introduction of the California HPPC for small employers was whether each employee should have the right to choose from the full range of participating plans, or whether employers should be allowed to restrict their employees' choices to one or a few plans. (The issue is not about the free speech of those employers who want to advise their employees that they have information reflecting poorly on one or another health plan. It is about the right of employers to limit the employees' choice.) Individual choice of plan is important - as explained earlier - to maximize the price elasticity of demand, and hence the incentive for health plans to reduce cost and price. Here, what one employer does has "spillover effects" on other employers. If many employers restrict choice, demand will be less elastic and prices will be higher for all.

Second, joining an AHP means limiting one's choice of doctors, for a year at a time, to those doctors contracting with that health plan. People generally want to be able to choose their own doctors. In a community where AHPs and managed competition are well developed, most doctors in town will be accessible through one or another AHP. So this system can accommodate people's desire to choose their doctors. (It makes sense for people to choose doctors by the group. If they become seriously ill, it will be important for their doctors to work well together.)

But if employers can pick and choose which AHPs their employees can select, the appeal of the whole idea is reduced. And the concept can be attacked by its opponents as interfering with individuals' choice of doctor. Furthermore, with limited employee choice of plan, portability of coverage is not guaranteed.

We understand why insurers want employers to limit choice. That is a way of making demand less price elastic, hence raising profit margins. It is much harder to understand why employers would want to limit choice, other than because of the costs of oversight of multiple plans, or concerns about quality or financial solvency. For example, a few years ago, at Stanford, we dropped one HMO because after a decade it had achieved only a very small market penetration and because we were concerned about its financial strength. The costs of oversight were too great for too few employees. The HPPC is meant to deal with these issues. It is very unlikely that small employers will achieve the ability to deal with them effectively. In fact, few small employers will want to take the required resources away from their core businesses to do so.

VI. HPPC Governance: Why Not the State?

The HPPC needs to balance two goals: first, a maximum effort to perfect the market in the interests of the participating employers, employees and other covered individuals; and second, to exercise social responsibility in the interests of equitable coverage for all. For example, the HPPC should accept all eligible groups and people who wish to enroll, regardless of health status. The HPPC should accept the goals of social responsibility in exchange for whatever franchise or incentive to join it is granted by government.

Governance needs to reflect this. There should be strong representation from the community of people actually served. And there should be some "public sector" participation to look after the aspects of social responsibility. (A HPFC board made up solely of small employers might be tempted to set up criteria to exclude coverage of very costly groups.)

Then why should not all HPFC functions be performed by a state agency? They could be. There is no technical reason a state agency could not be created to do the job. But we would have the following concerns. First, the HPFC is supposed to be a consumer-purchaser organization. State governments are already overly influenced by very well financed provider interests. Second, if state government controls the HPFC directly, elected politicians will surely find irresistible the temptation to turn HPFCs into sources of particularized benefits ("pork") to use to reward electoral supporters. Perhaps some deterioration in the standardization of the benefit package will occur; or some anti-managed care laws will be developed to please doctors and chiropractors, etc. And HPFC board seats might be used to reward cronies.

If state governments had done the job they are supposed to do, regulating insurance and health care, we would not be in the mess we are in now.

The subject of governance is large and complex and will be extensively discussed within the context of the health care reform debate. This is not the place to attempt answers. But the board of each HPFC should have strong representation by the small employer and individual subscriber communities, plus citizens with no financial ties to provider groups.

Appendix A: Industry Proposals for Small Group Reform

The insurance industry (the Health Insurance Association of America on behalf of commercial insurers, and the Blue Cross Blue Shield Association on behalf of their member plans) has put forward a set of proposed rules intended to ameliorate the situation of small groups [3], [4]. They are:

1. Guaranteed issue and renewal. That is, an insurer would not be allowed to refuse coverage to a group requesting it, nor to refuse to renew a policy. (In itself, this rule does not limit the price for coverage or renewal.)
2. Limits on the premiums that could be charged to any group, relative to the premiums charged to all other groups. For example, an insurer might be allowed to have no more than 10 "books of business" (roughly, product lines). Within each "book," the insurer could adjust the premium for the age and sex composition of the group. Then the rule would provide that the insurer could not charge a group within a "book" a premium more than 35 percent above or below the median premium in that book after adjustment for age and sex. This would still permit premium variations of at least a factor of 10. In addition, annual premium increases for any group would be limited to a maximum such as 15 percentage points above the trend, i.e., the average premium increase for the carrier's whole "book of business."
3. All members of a group must be covered without exclusion.
4. There could be no exclusions of coverage for care of preexisting medical conditions for people who had health insurance in the previous 6 months. For people not previously insured, there would be limits on exclusion of preexisting conditions.
5. The industry would create a "voluntary reinsurance mechanism" within the industry by which insurers would be able to place in a pooled arrangement the costs of care for patients each carrier considered to be high risks.

Viewed from the perspective of the problems of health insurance in general and of small groups in particular, these proposals do not do much to reduce high and rising costs or to create accountability for quality and costs.

First, they do nothing to bring the managed competition of Accountable Health Plans (AHPs) to the small group market. That is, they do not link this market to the engine of quality improvement and cost reduction.

Second, they do little to spread risk of high medical costs. Under the proposed rules, wide variations in premiums, based on medical cost experience, would still be permitted.

Third, they do nothing to achieve economies of scale in administration.

Fourth, they do not open this market to individual choice of plan. Thus, they do not address some of the most important causes of price-inelastic demand, which accounts for the ability of health plans to raise prices without losing many customers.

Fifth, guaranteed issue in the real world does not mean guaranteed marketing and genuine guaranteed availability. While guaranteed issue may mean an insurer may not turn down an employer requesting coverage, if a plan is not marketed and made readily available to a high-risk small employer, it is unlikely that the small employer will even know of the plan's availability. Even if a high-risk small employer happens to learn about a plan there is no assurance the insurer will readily and conveniently make itself available. Without a benefits office, or even a particular individual responsible for employee benefits, after a few unreturned phone calls and after being put on hold a few times, the small employer will probably give up pursuing the guaranteed issue plan.

APPENDIX B: CALPERS AS AN EXAMPLE OF A HPCC

The HPCC idea has at least one important counterpart in practical application: the Health Benefits Program of the California Public Employees' Retirement System (CalPERS).

CalPERS manages a health care coverage program for employees, retirees and dependents of the State of California and over 800 local government agencies that have joined the system. It now covers 900,000 people. Some participating agencies are large (several thousand employees) and some are small (down to two employees). The system is based on multiple choice of plan at the individual subscriber level. CalPERS offers, in total, a choice of 19 HMOs and two statewide PPOs. Of course, not all HMOs operate in all areas. But an employee in an urban area is likely to have a choice of at least 3 or 4 HMOs.

Before 1991, the State of California had a very inflationary employer contribution policy: it had agreed with employee unions that the state would pay the employee's premium in full up to the average of the four largest health plans in the system in the case of individual coverage, 90 percent of the average in the case of dependent coverage. As a result, there was no marketplace reward to the more efficient plans to keep their premiums below the average - so premiums rose as rapidly as premiums in general. As a consequence of the State's fiscal crisis, this formula was abolished and the maximum premium contribution was frozen in dollar amount from 1992 until the summer of 1995. As a consequence, employees have been paying the difference for more expensive plans and their price sensitivity in CalPERS is increasing. In the early-1993 premium renewals, the weighted average premium increase was 1.5 percent, far below that typical of the private sector.

CalPERS has been very successful in addressing two major problems of small groups: risk spreading and administrative costs. In the case of risk spreading, the employee of even the smallest group pays the same premium for a given coverage (e.g., Health Net individual coverage) as anybody else in the system, regardless of health status. Thus, risks are spread widely, over thousands and tens of thousands of people. Administrative costs are low: on the purchaser side, they are 0.5 percent of premium, a bargain for a small employer. There are no agent or broker commissions. On the carrier side, costs are also reduced by economies of scale. Five of the carriers each cover over 50,000 lives.

CalPERS is working to ameliorate the problems of customer information. It runs an annual enrollment with side-by-side comparative information on price. By standardizing the HMO benefit package, CalPERS is making it easier for employees to make value-for-money comparisons. CalPERS does an extensive survey of consumer experience every second year, and makes this information available to employees. More work remains to be done. But by covering 900,000 people, CalPERS can assemble the resources to do this at a low cost per person.

While CalPERS serves as a sponsor for its enrollees and is in this respect a HPCC, some of its design elements differ from those recommended in this paper, which we believe will be detrimental in the long run unless corrected.

Participation in CalPERS is voluntary (for public sector agencies other than the state), which we have suggested is not appropriate for HPPCs. As far as we can tell, CalPERS has not suffered adverse selection, as would be expected, on the part of the local government agencies that participate. Does this disprove the rule that voluntary HPPCs cannot work? We think not. CalPERS began as a program for state employees, retirees and dependents, so it began with considerable economies of scale. Combined with the ability to offer multiple choice to individuals, and stability of rates, these economies have made CalPERS attractive to better-than-average risk groups. This is a fairly unique situation.

REFERENCES

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- [2] Ellwood P., Enthoven A. C. and Etheredge L. *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System. Health Economics*, Vol. 1: 149-168 (1992) John Wiley & Sons, Ltd., New York.
- [3] Health Insurance Association of America, *Health Care Financing for all Americans: Private Market Reform and Public Responsibility*, Washington D.C. 1991.
- [4] Blue Cross Blue Shield, *Reforming the Small Group Health Insurance Market*, March 1991.

The CHAIRMAN. The committee stands in recess.
[Whereupon, at 12:45 p.m., the committee was adjourned.]

MENTAL HEALTH AND SUBSTANCE ABUSE UNDER THE HEALTH SECURITY ACT

MONDAY, NOVEMBER 8, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 12:02 p.m., in room SD-430, Dirksen Senate Office Building, Senator Wellstone, presiding.

Present: Senator Wellstone.

OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. The hearing of the Committee on Labor and Human Resources will come to order.

We will start out today with testimony from Representative Mike Kopetski from Oregon who has really, by all accounts of all people who are fiercely concerned about mental health and substance abuse, been one of the true leaders in the U.S. Congress.

We will then follow with Dr. Bernie Arons, who will present the administration's mental health and substance abuse benefit package and talk about the associated costs and pricing, which we want to look at very carefully today. In many ways, I think this is going to be a critical kind of nuts and bolts discussion and hearing that we will have today.

The next panel consists of Frank McArdle, who is with Hewitt Associates and who will speak to the pricing of mental health and substance abuse benefits in a health care package. Mr. McArdle brings a wealth of experience and expertise to this.

Dr. Richard Frank is a professor of health economics at Johns Hopkins University. He will address the cost basis of the administration's health plan and alternative pricing views. One of the things we want to try to do today is get clear on some of the data and the actuarial assumptions and what numbers we are really talking about; what, really, are we talking about by way of costs for the country of a mental health package that would be comprehensive and would also be flexible.

Dr. John Docherty will be speaking today based on his affiliation with Tufts University, as I understand, and that will be the focus of his testimony. He is going to be talking about some of the data and costs associated with good managed health care plans, and will talk about the question of where seriously mentally ill people would fit in, and is also going to be talk about some of the questions that deal, again, with costs.

Finally, closing the hearing will be Dr. Areta Crowell, who is director of the Los Angeles County Medical Health Department. She will address the issues, economic and social, of universal health care that must integrate both the private and public sectors. Los Angeles County has 9.1 million people, which is larger than 42 States, so we will assume that her testimony is not insignificant.

Additionally, I want to include for the record a really eloquent and gracious letter from Rosalynn Carter, whose office called yesterday. She has the flu and cannot be here, and in this letter, which I will not read, there are lots of nice things said about people who are here today, but the most important point is that she expresses her strong commitment to this and will indeed testify before the committee. So we will have another hearing, and we will have Mrs. Carter here to testify. I also have a statement from Senator Dodd.

[The prepared statements of Senators Wellstone, Dodd, and a letter from Mrs. Carter follow:]

PREPARED STATEMENT OF SENATOR WELLSTONE

I have long felt that universal coverage and comprehensive mental health and substance abuse benefits must be an integral part of any reform of the health care system. For far too long, these benefits have been put in parentheses.

The day is finally close at hand, thanks to an Administration and many of my colleagues in both the House and the Senate who have taken this tremendous task head-on. The time, energy and ideas that have gone into developing new ways of thinking about health care are enormous—and it is now up to all of us to determine if that energy will result in needed change, perhaps even saving this country from economic disaster, or if all that energy will be wasted.

Today I am pleased to have with us many of those individuals who have committed so much to these issues. And I thank each of them for giving of more time to be here with us today, sharing their expertise with us. I am especially and personally pleased that we have a statement from someone to whom we owe so much for her efforts in making mental health care a reality, former First Lady Mrs. Rosalynn Carter. Mrs. Carter's statement expresses her disappointment that illness prevents her from joining us here today as planned, and her commitment to testify at a subsequent hearing.

The President and I agree that security, universal coverage and comprehensive benefits are the principles upon which national health care must be based. Both the President's and the single-payer bill which I introduced even promise that security in their titles. I would add that we must define universal coverage and comprehensive benefits to include access to the same high quality care for everyone.

It is difficult to feel secure going to work if your medical insurance does not cover mental health—psychological and family problems are the largest cause of time and productivity lost at work.

It is equally difficult to ask for help when the only insurance treatment covered by your insurance is a kind of care that you and your health care provider don't feel is best, or that you know you can't afford. Too many existing plans are tilted towards such inpa-

tient care, at the neglect of needed and less costly outpatient and intermediate community based services.

Escalating health care costs threaten our nation's financial security, and here again, lack of coverage for mental health and substance abuse services plays a role. 30-70% of all visits to physicians are for issues surrounding mental distress, leading to repeated visits and possibly unnecessary medical care, when effective mental health treatments would solve the problem.

What do we mean by a national health care program that provides security and comprehensive benefits?

Security means knowing that a comprehensive physical health and mental health benefit package is available to all Americans, not just to those with enough money to "buy the best." Security is based on the fact that you and your children will be covered for those medical and emotional problems that cost all of us in terms of lowered quality of life, reduced wages, and increased offset to more expensive crisis intervention treatments.

Security means a guarantee that choice and flexibility of services are hand in hand for all Americans. You've heard a lot about choice of doctors and other providers—and I strongly agree with that as an essential concept. However, I also believe that there must be choice in how consumers and care-givers use the benefits that are available. In accessing the mental health benefit people must have the right to choose the best therapy outpatient psychotherapy as opposed to inpatient—because it is the treatment of choice, not because artificial limits in days or dollars covered tilt towards one versus the other.

We now have a health care reform plan from the Administration, and we're going to hear the most recent details about it this morning. There is a lot to applaud in that plan. The President and the White House Task Force led by Mrs. Clinton have taken an important first step in recognizing the crisis that we have lived with for far too long—the crisis of denying adequate mental health and substance abuse care to millions of our fellow citizens.

Not only have we denied them adequate mental health care, we have come close to bankrupting the nation in doing so. Instead of providing a solid plan for physical and mental health care, we have forced millions into emergency rooms, into crisis centers, into living on the streets and off society. What we really want—and what the Administration has begun—is a system that says mental health care is a basic right of all Americans. That belief is the essential concept on which the Senate Working Group on Mental Health continues to base its efforts.

And the plan has taken an important step in recognizing the inclusion of basic mental health and substance abuse care in any basic health plan.

Congratulations, however, are tempered by several important concerns.

First, the outpatient mental health copayment, the amount that has to be paid by the consumer for each visit, is 50%, while the copay for medical services is 20%. This extremely high copay will prohibit use of the benefit by those who need it the most. For people who can afford it, the difference between paying 20% and paying 50% for each visit may not keep them from seeking help. But

for those on the financial edge, who are often on a concurrent emotional edge, the high copay will make services unobtainable.

A similar financial burden is placed on those who must use inpatient care. The Administration's decision to require them to pay, by themselves, the entire first day of hospitalization puts a financial burden on people in need at what could be one of the most difficult times in their lives. Again, discouragement from even a short inpatient stay when it's necessary could make the difference between an individual who can be restored to a meaningful life, and one who is lost to us forever, probably at far greater cost.

The second concern is that the Administration's plan waits until 2001 to give mental and physical health parity. We don't think the country can wait that long. If we don't begin to restructure the tilt of mental health and substance abuse services now, we may not be able to afford expanded benefits later. We'll hear more today about ways to provide excellent care and do it for what we can afford.

To achieve security and equality in a mental health and substance abuse benefit, the national health plan must have fair copay amounts, and flexibility in how benefits are used by the consumer.

Our new national health care system must be a revolution in how we take care of our children, a primary concern for our guest, the distinguished Representative from Oregon, Mike Kopetski. Approximately 14 million children suffer a diagnosable mental illness. Yet research tells us that some severe problems show improvement in 26 to 52 sessions, generally beyond the Administration's 30 session limit.

Why should the design of our mental health benefit force the decision to hospitalize a child, removing her from her family, from her support system, just to use a health plan benefit? When hospitalization is the treatment of choice, it should be available and covered, but we don't want to force that choice just because that's the only mental health benefit left in the family's coverage.

We must be fair to the severely mentally ill, people for whom the distinguished Senator from New Mexico, Senator Pete Domenici, has been a strong champion. Will the needed help be there for them under the new health plan? When coverage for necessary inpatient care is exhausted, will we continue to force them into a public sector that has increasingly fewer resources? Will those who now suffer alone continue to be outside the security blanket promised to us in national health care? Or will we begin to integrate them into the community in an orderly and affordable way, by phasing in widespread nonresidential services, ultimately lifting a huge financial burden from our states, and restoring millions to a meaningful life?

We must meet the needs of our rural citizens, and consider building in dollars for treatment rather than only more money for hospitals and other buildings. We must fund the people who will treat those in our rural areas, through community care centers, clinics, county mental health centers, and similar groups of people helping their neighbors. That's the very essence of what people in rural areas want—and deserve.

And we must meet the needs of our workers, many of whom are underinsured or uninsured—or who can't change jobs for fear of losing their health insurance. While we have been talking about

changing the way we think about and treat mental health issues, corporate America has been taking action. Major corporations, have been increasing their emphasis on outpatient psychotherapy for their workers. And overall costs for mental health have gone down. These companies, and the National Institute for Mental Health, have shown that people with mental illnesses seek treatment about the same proportion as people with physical ailments—utilization does not skyrocket.

And the data go on—for the elderly: Medicare estimates that when retirees seek psychological treatment, the patient will reduce his or her physical health care costs by 15-20%. Outpatient alcohol treatment: Alcoholics make up 25-40% of the people in medical hospital beds and use health care at a rate four times that of non-alcoholics. After mental health treatment, work productivity increases; absenteeism declines.

We must encourage the use of cost-effective mental health and substance abuse treatment. The copay for mental health must be the same as it is for all medical treatments. We cannot ask those in catastrophe to pay a one-day deductible for inpatient care. We are too sophisticated to continue an artificial and backwards discrimination against psychological problems and treatment. Security comes from knowing that the benefits are there if you ever need them, and that you can afford to use them.

Security comes from knowing that whatever benefit people need in order to keep themselves healthy and functioning well is there. Fairness comes from a system that allows the middle-income and low-income to have meaningful access to its benefits.

We have a long way to go before we enact a health care reform plan, but after decades of rhetoric, the time for adopting a fair and national health plan that provides true security is here.

The evidence is clear, and I ask that the 30 articles submitted to us by Dr. Docherty, articles by Rice, Kelman, and Miller, an article by Well, et al., and the materials provided by other witnesses be entered into the record, and that we keep the record open for the next two weeks.

We know that mental health care reduces costs for physical illnesses. And we know it works. We have learned a lot about how to take care of ourselves, both physically and mentally. No longer should we discriminate against mental health services.

We need national health reform. We will get national health reform. And that reform must guarantee security and equality through a comprehensive benefits package that provides fair and affordable benefits package for physical health, mental health and substance abuse treatments.

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, we are here today to discuss two aspects of health care that are not talked about enough: mental health and substance abuse treatment. Not only can mental illness and substance abuse directly affect physical health, but they also can exact a large emotional and financial toll on our nation's individuals, families and communities. Today we will examine how the President's health security act would tackle these problems.

Mental health should not be a peripheral concern: it is integral to meaningful health care reform. Studies have shown that mental health-related problems account for 20 percent of primary health care visits. For families with members suffering from mental illness, the cost for treatment—whether in-patient or out-patient—can be staggering, and currently insurance providers vary widely in their coverage. Insurance must offer families real assistance in covering these costs. Substance abuse treatment should also play an important role in our efforts to reform the health care system. A study by the Johnson Foundation found that the abuse of alcohol, tobacco and other drugs cost the nation \$238 billion during 1990 in lost productivity, medical costs, crime costs and destruction of property.

Substance abuse can also transmit health care problems from one generation to the next. We are all aware of the terrible problem of drug-exposed infants and children.

We certainly cannot solve all our social problems through health care reform, but I think we can make significant progress in these areas as part of our efforts. I am pleased that the health security act has included coverage for substance abuse treatment and mental health. I look forward to the opportunity we will have today to examine these issues more closely.

Nov. 8, 1993.

Hon. PAUL WELLSTONE,
U.S. Senate,
Washington, DC.

DEAR SENATOR WELLSTONE: As you know by now, I am unable to appear before the Senate Labor and Human Resources Committee this morning because of a temporary illness. I regret the necessity for this cancellation and hope it will not be a great inconvenience to you or the other members of the committee.

I had been looking forward to testifying on the issue of including mental health in health care reform. As you know, I have devoted much of my energy for over twenty years toward bringing attention to the needs of people with mental illness. The hearings you are about to begin hold great promise for addressing the historic inequities in health care experienced by the mentally ill, and I was most grateful for your invitation to appear before the committee.

During the past year, The Carter Mental Health Task Force and I have worked closely with the mental health community to discuss the issues related to including adequate benefits in health care reform. The degree of cooperation and willingness to work together exceeds anything I have seen in the mental health field in my entire career. This represents, I believe, a recognition of the singular importance of health care reform to profoundly affect the welfare of people with mental illness and their families for many years to come. Your leadership in this area is appreciated by all of us, and we shall support you in your effort.

I hope that you will see fit to invite me again at a later time. Providing decent mental health care is, in my view, one of the most important goals we should have in a reformed health system in America.

Sincerely,

ROSALYNN CARTER.

Senator WELLSTONE. We welcome Congressman Kopetski. I thank you for being here, Congressman.

STATEMENT OF HON. MICHAEL J. KOPETSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. T4Kopetski. Thank you, Senator Wellstone.

It is a pleasure for me to be here this morning. I thank you for this opportunity to appear today before the committee, and I thank you for calling a hearing on the cost of providing benefits covering mental and substance abuse disorders.

I believe we must not lose the opportunity provided by health care reform to improve our Nation's treatment of the mentally ill. In reaching our goal of providing equitable coverage for these benefits, it is important that we start with an understanding of the costs of these benefits.

Let me say, Mr. Chairman, that I was distraught to learn this morning that the former First Lady, Mrs. Carter, could not attend this hearing. We all wish her well. She has been a strong pioneering voice for those with mental disorders, and her experience and advocacy have helped bring us to where we are today. She will continue to be a valuable asset and an excellent spokesperson on this issue, and I am sure we will see her up here on the Hill before long.

Mr. Chairman, let me commend you as well for your excellent work on behalf of those with mental disorders. It is an uphill battle to protect or improve the mental health benefit within the President's proposal. I look forward to working with you in this battle. The mental health community owes you a debt of gratitude for your work on these issues, and I know that they as well as all Americans will praise you for your efforts by the time health care reform is enacted.

Concerned, effective and aggressive leaders such as yourself are critically important to efforts to improve access to quality mental health services for all Americans.

Mr. Chairman, I would like the Senate to know that we have a good base of support in the House for equitable access to mental health care services. At this time, there are 222 cosponsors of H. Con. Resolution 52, a resolution introduced by myself on behalf of the House Working Group on Mental Illness and Health Issues. All of these groups came together and agreed upon the language and on the resolution itself and have been working to gain this tremendous number of cosponsors for this legislation.

This resolution expresses the sense of the Congress that equitable mental health care benefits must be included in any health care reform legislation passed by the Congress. Thus a clear majority of House members, both Republican and Democrat, and our one independent as well, leadership people on both sides of the aisle, have all come together and said that we must treat mental health benefits the same as we do physically related injuries.

I am working with these and other members to help ensure passage of the strongest mental health benefit possible.

The President's health care reform bill is deficient in terms of the level of care provided for those with mental health and substance abuse disorders. It contains significant and important measures for the mentally ill, such as no lifetime expense cap on mental health care and coverage for prescription drugs. These are necessary first steps.

However, the President's package continues the current practice of placing arbitrary limits on virtually all types of mental health care services. While the President's bill calls for comprehensive coverage of mental health and substance abuse disorders by the year 2001, I have great concern about the prospect of delaying equitable coverage for 8 years. This is a long, long time to wait for the millions of Americans who have mental or substance abuse disorders.

This is a long time to be discriminated against and a long time to continue the current, two-tier system of care for these people.

And in reality, there is no true guarantee that this phase-in will occur. I hope we can improve the mental health provisions of the bill as it moves through the Congress. I also want to recognize the important work of Senator Domenici, who has been here much longer than you and I, Senator Wellstone, but has carried the banner for those with severe mental illnesses in this Nation. He has stepped forward long before it was popular. It is no doubt an area that has risk attached to it in terms of political reputations, quite frankly. Politicians for too many years have been afraid to embrace this issue because of the potential stigmatism that can occur and has occurred historically surrounding mental illnesses.

Senator Domenici, though, has stepped forward and has been a great leader on Capitol Hill for this, and you and I are working together with him to assure equitable treatment for those in our society who need these services.

Thank you again for this opportunity.

Senator WELLSTONE. I thank you, Congressman.

I think I will move forward with the next panel, but I think that your testimony is very important, for several reasons, but the one reason I want to cite is your determination to keep working to make sure that ultimately, what becomes the final package of benefits and the final reform is one that will work well for people.

I thank you for your strong testimony.

Mr. KOPETSKI. Thank you, Senator. We will win.

Senator WELLSTONE. Dr. Arons, welcome.

Let me first mention for everyone here that Dr. Arons—Bernie—I do not know if he has been suffering from the same bug that Rosalynn Carter has, but he too has been under the weather and was kind enough, even though I know that as of yesterday, he was not feeling great, to be here today. So I thank you very much, Dr. Arons.

I also want to thank Dr. Arons for his leadership in this area. I have come to know him, and I know how committed he is, I know how hardworking he is, and I very much appreciate what you have done. I think we have much work to do together.

Thank you for being here. And I really should have said to everyone here that Chairman Kennedy is holding a hearing in Massachusetts today, and that Senator Domenici was going to be here earlier, and then we had to juggle things around; and that Senators Harkin, Simon, and Rockefeller, as well as other Senators, have very strong interests in this area.

**STATEMENT OF DR. BERNARD ARONS, ACTING DIRECTOR,
THE CENTER FOR MENTAL HEALTH SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Dr. ARONS. Good afternoon, Mr. Chairman.

I am Dr. Bernard Arons, a psychiatrist and the acting director of The Center for Mental Health Services, a part of the Substance Abuse and Mental Health Services Administration in the Public Health Service.

Recently, it was my privilege to serve as the chair of the mental health and substance abuse working group cluster of the Presi-

dent's Task Force on National Health Care Reform. I am pleased to be here today to discuss an important aspect of the President's Health Security Plan—the availability of coverage for mental health and substance abuse services. Estimates put the 1988 annual economic cost to society of mental health and substance abuse at over \$273 billion, including costs due to direct care, lost productivity, and the costs of the welfare and criminal justice systems.

Despite the obvious importance of including mental health and substance abuse services in health care reform, we must acknowledge that some have questioned this, believing that we cannot afford such coverage.

There are several strong arguments, however, for providing these services. First, we now have cost-effective treatments for mental illness and substance abuse disorders, and high rates of efficacy are being achieved across the spectrum of mental health and substance abuse diagnoses.

For example, over 80 percent of individuals with depression respond to treatment.

Second, mental illness and substance abuse often result in physical illness, inability to work, impaired relationships and, at times, crime and homelessness. Persons receiving mental health and substance abuse services use less medical care and work more effectively. Thus, much of the savings thought to result from excluding mental health and substance abuse services are false, since additional, inappropriate medical care could result.

Finally, mental health and substance abuse services already are part of the health care deliver of the United States. Nearly all medium and large firms include some mental health and substance abuse coverage in their health insurance plans, and insurance coverage for mental illness and substance abuse is seen as an essential component of health insurance. Benefits for treating mental illness and substance abuse as an integral part of a health insurance package are a wise investment in America's future.

Although many health insurance plans provide coverage for mental illness and substance abuse, they often have serious flaws. Private insurance coverage of mental health and substance abuse care differs substantially in structure from general medical care. Such coverage discriminates between mental health and substance abuse care and general medical care by limiting the number of visits or days of treatment, by establishing lifetime limits for mental health and substance abuse benefits, and by excluding pre-existing conditions. Thus, even when plans cover such services, individuals may be partially barred from treatment.

Limits on access to care have resulted in shifting both the responsibility and cost of care onto the public mental health and substance abuse system. For children and adolescents, the burden and cost of care have also been shifted to the child welfare, education, and juvenile justice systems. Even worse, sometimes these overburdened systems are not able to provide needed services, and the individual goes without treatment. Eventually, we all bear the costs of delays or gaps in service provision.

Effective technologies do exist for treating mental illness and substance abuse in community-based settings. A comprehensive array of services, along with flexibility to provide such services to

individuals based upon medical necessity, produces better outcomes than those experienced with traditional benefits.

There is also evidence that capitated approaches result in less costly provision of health care services. Increasingly, both the public and private sectors have been developing systems of care that incorporate such features.

The President's Health Security Plan will emphasize these desirable elements and make mental health and substance abuse services an integral part of a national system of health care. The President's proposal represents a meaningful improvement over today's typical insurance policy, that covers only a narrow range of services and that encourages inpatient care over more cost-effective alternatives.

The mental health and substance abuse benefit proposed by the President meets the following goals. It ensures that persons with mental and substance abuse disorders and their families have access to specialized services. It ensures that health plans have the flexibility to provide the appropriate types, mix, and level of services for each individual consumer. It encourages the development and use of alternatives to hospitalization to ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual. It reduces the shifting of costs and responsibilities to the public sector and encourages the integration of the public and private delivery systems.

The President's benefit proposal covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the proposal does not limit intensive treatment to inpatient coverage in hospitals only, but broadens it to other residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs. These services will discourage expensive inpatient hospital care and encourage community-based care.

The benefit design also provides incentives for health plans to move to a managed benefit and in fact requires all plans to have a comprehensive array of benefits. Initially, for mental illness, up to 30 days of hospitalization are covered per calendar year. Additional days are available if they are determined to be required by a health care provider designated by the plan, for an annual aggregate limit of 60 days. For substance abuse, hospitalization is limited to medical detoxification associated with withdrawal from alcohol or drugs.

To encourage cost-effective care, residential treatment may be substituted for hospitalization.

Intensive nonresidential treatment will be offered as an alternative to inpatient or residential care. Intensive nonresidential treatment can be substituted for inpatient care at the rate of two intensive nonresidential days for one inpatient day.

Outpatient services are also covered. These include screening and assessment, diagnosis, medical management, case management, crisis services, and somatic treatment services. Initially, 30 visits for psychotherapy sessions and collateral services are covered annually. For psychotherapy sessions, there are 50 percent copayments in the higher cost-sharing plans and \$25 per visit for

the lower cost-sharing plans. These copayments and other expenses do not count toward the annual out-of-pocket limit on cost-sharing. Additional outpatient psychotherapy visits may be available by exchanging, at a one to four rate, inpatient days for outpatient psychotherapy visits following the same copayment schedule as the first 30 visits.

For substance abuse, outpatient services include 30 group therapy visits following residential or intensive nonresidential treatment. Other outpatient substance abuse services may be provided by the health plan by exchanging residential days for outpatient visits on a one to four basis.

Health plans may offer case management services. These services include those that assist individuals in gaining access to needed medical, social and educational services.

Day limits on services are to be eliminated by January 1, 2001, at which time individuals may receive all medically necessary care, regardless of its type, scope, or duration. At this time, out-of-pocket expenses for intensive nonresidential and outpatient services will apply toward annual out-of-pocket limits.

The proposal for comprehensive coverage in 2001 represents a dramatic step toward eliminating the historic discrimination against mental illness and substance abuse.

This administration is committed to making mental health and substance abuse services an integral part of a national system of health care. The President's benefit proposal represents a meaningful improvement from today's typical insurance policy that covers only a narrow range of services. The 2001 benefit takes the essential step of eliminating the historic discrimination against mental illness and substance abuse. To meet this goal, we must create a quality delivery system grounded in care management and collaboration between States and health plans to integrate public and private delivery and financing structures.

We wish to work with you to make sure that we can meet this objective.

Thank you.

[The prepared statement of Dr. Arons follows:]

PREPARED STATEMENT OF DR. BERNARD ARONS

Good afternoon, Mr. Chairman, and Members of the Committee. I am Dr. Bernard Arons, a psychiatrist and the Acting Director of the Center for Mental Health Services, a part of the Substance Abuse and Mental Health Services Administration in the Public Health Service. Recently, it was my privilege to serve as the Chair of the Mental Health and Substance Abuse Working Group Cluster of the President's Task Force on National Health Care Reform.

I am pleased to be here today to discuss an important aspect of the President's Health Security Plan—the availability of coverage for mental health and substance abuse services. Mental illness and substance abuse disorders are common problems, affecting more than 50 million Americans this year. Estimates put the 1988 annual economic cost to society of mental illness and substance abuse at \$273 billion, including costs due to direct care, lost productivity, and the cost of welfare and criminal justice systems.

The Need for Mental Health and Substance Abuse Coverage in Health Care Reform

Despite the obvious importance of including mental health and substance abuse services in health care reform, we must acknowledge that some have questioned this, believing that we cannot afford such coverage. There are several strong arguments for providing these services. First, we now have cost-effective treatments for mental illness and substance abuse disorders, and high rates of success are being

achieved across the spectrum of diagnoses. For example, over 80 percent of individuals with depression respond to treatment. Second, mental illness and substance abuse often result in physical illness, inability to work, impaired relationships, and at times, crime and homelessness. Persons receiving mental health and substance abuse services use less medical care and work more effectively. Thus, much of the savings thought to result from excluding mental health and substance abuse services are false, since additional, inappropriate medical care could result. Finally, mental health and substance abuse services already are part of health care delivery in the United States. Nearly all medium and large firms include some mental health and substance abuse coverage in their health insurance plans, and insurance coverage for mental illness and substance abuse is seen as an essential component of health insurance. Benefits for treating mental illness and substance abuse, as an integral part of a health insurance package, are a wise investment in America's future.

Problems with Existing Coverage

Although many health insurance plans provide coverage for mental illness and substance abuse, they often have serious flaws. Private insurance coverage of mental health and substance abuse care differs substantially in structure from general medical care. Such coverage discriminates between mental health and substance abuse care and general medical care by limiting the number of visits or days of treatment, by establishing lifetime limits for mental health and substance abuse benefits, and by excluding preexisting conditions. Thus, even when plans cover such services, individuals may be partially barred from treatment.

Limits on access to care have resulted in shifting both the responsibility and cost of care onto the public mental health and substance abuse system. For children and adolescents, the burden and cost of care also have been shifted to the child welfare, education, and juvenile justice systems. Even worse, sometimes these overburdened systems are not able to provide needed services, and the individual goes without treatment. Eventually, we all bear the cost of delays or gaps in service provision.

Another consequence of the current benefit structure has been the creation of excess inpatient hospital capacity in many areas of the country, despite the fact that effective technologies exist for treating mental illness and substance abuse in community based settings. A comprehensive array of services, along with the flexibility to provide such services to individuals based upon medical necessity, produces better outcomes than those experienced with traditional benefits. There is also evidence that capitated approaches result in less costly provision of health care services. Increasingly, both the public and private sectors have been developing systems of care that incorporate such features.

The Health Security Plan

The President's Health Security Plan will emphasize these desirable elements and make mental health and substance abuse services an integral part of a national system of health care. The President's proposal represents a meaningful improvement over today's typical insurance policy that covers only a narrow range of services, and that encourages expensive inpatient care over more cost-effective alternatives. The mental health and substance abuse benefit proposed by the President meets the following goals:

- It ensures that persons with mental and substance abuse disorders, and their families, have access to specialized services.

- It ensures that health plans have the flexibility to provide the appropriate types, mix, and level of services for each individual consumer.

- It encourages the development and use of alternatives hospitalization, to ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.

- It reduces the shifting of costs and responsibilities the public sector and encourages the integration of the public and private delivery systems.

Mental Health and Substance Abuse Benefits Under the Plan

The President's benefit proposal covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the proposal does not limit intensive treatment to inpatient coverage in hospitals, but broadens it to other residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs. These services will discourage expensive inpatient hospital care and encourage community-based care. The benefit design also provides incentives for health plans to move to a managed benefit, and in fact requires all plans to have a comprehensive array of benefits.

Initially, for mental illness, up to 30 days of hospitalization are covered per calendar year. Additional days are available if they are determined to be required by a health care provider designated by the plan, for an annual aggregate limit of 60 days. For substance abuse, hospitalization is limited to medical detoxification associated with withdrawal from alcohol or drugs.

To encourage cost-effective care, residential treatment may be substituted for hospitalization.

Intensive nonresidential treatment will be offered as an alternative to inpatient or residential care. Intensive nonresidential treatment can be substituted for inpatient care at the rate of two intensive nonresidential days for one inpatient day. This substitution is available at the discretion of the health plan, and applies only to the first 60 days of intensive nonresidential care.

Outpatient services are also covered. These include screening and assessment, diagnosis, medical management, case management, crisis services and somatic treatment services. Initially, 30 visits for psychotherapy sessions and collateral services are covered annually. For psychotherapy sessions, there are 50% copayments in the higher cost sharing plans and \$25 per visit for the lower cost sharing plans. These copayments and other expenses do not count toward the annual out-of-pocket limit on cost sharing. Additional outpatient psychotherapy visits may be available, by exchanging, at a 1 to 4 rate, inpatient days for outpatient psychotherapy visits following the same copayment schedule as the first 30 visits.

For substance abuse, outpatient services include 30 group therapy visits following residential or intensive nonresidential treatment. Other outpatient substance abuse services may be provided by the health plan by exchanging inpatient days for outpatient visits on a 1 to 4 basis.

Health plans may offer case management services. These services include those that assist individuals in gaining access to needed medical, social and educational services.

Day limits on services are to be eliminated by January 1, 2001, at which time individuals may receive medically necessary care. At this time, out-of-pocket expenses for intensive nonresidential and outpatient services will apply toward annual out-of-pocket limits. The proposal for comprehensive coverage in 2001 represents a dramatic step toward eliminating the historic discrimination against mental illness and substance abuse.

Summary

This Administration is committed to making mental health and substance abuse services an integral part of a national system of health care. The President's benefit proposal represents a meaningful improvement from today's typical insurance policy that covers only a narrow range of services. The 2001 benefit takes the essential step of eliminating the historic discrimination against mental illness and substance abuse. To meet this goal we must create a quality delivery system grounded in care management and collaboration between States and health plans to integrate public and private delivery and financing structures. We wish to work with you to make sure that we can meet this objective.

Thank you.

Senator WELLSTONE. Thank you, Dr. Arons.

One of the concerns that I have—and I think I speak for others as well—is that we may be creating a real problem for people who use outpatient treatment. The 50 percent copay, or the \$25 even in the lower price, could very well price people out of care, and if we are not going to count the out-of-pocket expenses for outpatient treatment toward the overall cap, aren't we essentially creating the wrong incentives and disincentives so that people will then move more toward the inpatient, which is more expensive care?

Dr. ARONS. First let me say that there are a number of outpatient benefits that are available without the increased cost sharing and without the increased limits, so that crisis intervention when necessary, assessment of condition, medical management, brief office visits and the like, are all covered the same as the rest of health care at the same copayments and without limit.

Senator WELLSTONE. The psychotherapy is not.

Dr. ARONS. But the psychotherapy is not. The psychotherapy, for those individuals who are categorical recipients of Medicaid, will have a limit on their out-of-pocket cost-sharing which is limited to 20 percent of the cost-sharing; that is the same as for the rest of health care in that there are limits, and there is a reduction in the cost-sharing.

You are correct, though, for those individuals who do not meet those criteria, there would need to be substantial out-of-pocket payments for these services.

Senator WELLSTONE. What is the rationale for the 50 percent copay and for not counting this toward the cap?

Dr. ARONS. It is my understanding, and in our deliberations of these concerns, there was extensive discussion as to how one controls services in the mental health area. And there is basically a debate and discussion between management of a benefit in which the plan determines what number of visits, what indications, what criteria an individual needs to meet in order to be eligible for coverage, and what might be called demand side, or restrictions involving the consumer paying more, which then tends to make an individual reduce his or her utilization of care.

In this situation, the belief was, and I think the assessment was that those management systems necessary to control outpatient psychotherapy are not yet in place throughout the country, and so there would be a need for some increased copayment to help control utilization.

Senator WELLSTONE. Why couldn't we at the very minimum, though, apply that copay toward the overall cap? I mean, it seems to me that that would go a long way toward reducing what I think would be some of the financial hardship. There is a long way between Medicaid and people in the high income range, and my fear is—and we will hear testimony from others, who use other data that I think quarrel with the assumption about dangers of overutilization—but why couldn't we at the very minimum apply that to the overall cap?

Dr. ARONS. I think the reasoning behind that is that if in fact one needs an increased copayment to control utilization, by applying it to the overall cap, there would come a point—let us say it is set at \$1,500 or \$2,000, that cap—there would come a point where beyond that, the care would be free, and there would be no more cost-sharing on the part of the individual. And with free care, if the assumption is that that would result in increased utilization, you would lose the benefit of that control of the increased copayment. That is the reasoning.

Senator WELLSTONE. I think I want to do in today's testimony is come back to that point—I know others are going to speak to it—because I think it is a point of contention and one that we need to zero in on.

Dr. Arons, let us talk numbers, if we can. What percentage of the overall premium is for the mental health and substance abuse package—and I guess what I am most interested in, I mean, if I could have one wish for this hearing above and beyond any other, it is to get a clear estimate from you on what the actual dollars would be on a per capita basis for the mental health and substance abuse benefit. We have heard some different figures, and I think

if we could have a figure, then we could know what we are talking about, and we could really get down to a careful evaluation.

Do you have a figure for us?

Dr. ARONS. Mr. Chairman, there is not a simple answer to this question. We looked extensively at existing health plans, and the sorts of percentages that mental health and substance abuse comprise as part of overall health care spending vary tremendously in existing health care plans, from some plans that have perhaps 3 to 4 percent part of the premium to those that have more like 12 to 15 percent, so there is a tremendous range. The estimates for this package are being reviewed and are being done, and will be coming to the Congress as part of an overall assessment of the costs of the premium and the costs of health care.

So I am not prepared at this time to discuss the specific number for the mental health portion of that.

I believe it is also important to note that mental health and substance abuse will be part of an overall premium and that there will be the assumption that this will be covered along with the rest of health care.

Senator WELLSTONE. Well, let me just ask you, do you have any idea as to when, just in terms of the dollar amount per covered life, you would be able to provide us with that information? I mean, as you know, this has become in many respects the critical point. That is why I say this is a nuts and bolts session. I mean, I could have had an opening statement where I could have gone on for some time about the importance of ending the discrimination in parity. I could have talked at some length about the importance for those with serious mental illness of community-based health care and where does that fit into this—and we will get to that. I could argue—and will argue—about the copay for outpatient and psychotherapy.

But most important of all, I just think the fear that some of us have is that we have seen—and there will be some people testifying here on the basis of some Fortune 500 plans—we have seen some actuarial work which points out that for \$231 per covered life, you really could provide a package of benefits for mental health and substance abuse that would be comprehensive and flexible. Yet the figures that we are hearing are much higher than that. And many of us are concerned about those being old data, so I guess at the very minimum I would like to know when you think you could have a figure for us.

And then my second point, which is the merging of two questions together, is, is the administration open to reconsidering the basic package of benefits if in fact we can bring more up-to-date information and data from a variety of different people with a wealth of experience with some of these plans?

Dr. ARONS. Mr. Chairman, let me say that these estimates are not a simple matter. Again, we have looked very carefully—and I assume you will be hearing later this afternoon about the cost of a benefit in various companies. The difficulty that we often face is that each estimate and each particular insurance may be covering a particular population, and we are proposing a coverage for the entire American population across the spectrum, so that what

might be true for an employee population of one of the Fortune 500 companies may not be true for this premium.

It is my understanding that the documentation of the modeling that is being used to estimate the premium for the whole plan is being finalized and should be available for the record quite shortly.

We will be providing our best estimates based on the individuals that we have working on this modeling approach to the documentation of the premium. We will be providing our best estimates. We know that you will also have individuals available who will be making their best estimates, and the administration stands ready to discuss this further and to make use of the best estimates that are available for the country as a whole.

Senator WELLSTONE. I appreciate that. I think that is going to be very important.

Dr. Arons, how do you define substance abuse counseling? Let me just read some language from the Act. Why can't providers, and I quote, "provide no item or services other than substance abuse counseling and relapse prevention, medical management, or laboratory and diagnostic tests"?

Some of the people in the field tell me that that goes against the goal of having an integrated service delivery program whereby clearly, if you are working with someone, let us say, in substance abuse, they may want to talk about a problem with a child; they may want to talk about a problem with another member of the family. And the way this language reads, a caregiver would not be able to cover that ground, and yet that seems to go against the notion of an integration of services and support.

Dr. ARONS. The bill as transmitted to Congress does have that language in it. We are in the process of a general review of the entire bill for all language, and to look at its consistency one part to the other. It is clear that there are certain requirements in other parts of the bill for qualifications of providers and so forth, and we believe that that is more than sufficient to cover whatever concerns were captured in this language.

So it is my sense that once this is reviewed for consistency that there may be some clarification of that language.

Senator WELLSTONE. We might be able to just do a technical correction of some sort, yes.

Dr. ARONS. Perhaps.

Senator WELLSTONE. I want to zero in on one or two final questions—are you feeling all right.

Dr. ARONS. Yes.

Senator WELLSTONE. I mean, you are doing great, but I want to make sure you are in good health.

Dr. ARONS. I am doing fine, Senator.

Senator WELLSTONE. Well, I do thank you. It is no fun when you are going through the flu.

I want to talk about the one-to-four swap that you mentioned. This has become an issue that I am attempting to study and learn more about. The way the language reads, as I understand it, there is discretion given to health care plans not to expand the mental benefits beyond the 30-day and 60-day limits described in the Act. In other words, it is up to them as to whether or not they are will-

ing to let someone do this swap of 4 more days outpatient in exchange for giving up 1 day of your 60 days per year; is that correct?

Dr. ARONS. Throughout this benefit, there are a number of opportunities for discretion to the plan to decide whether an individual gets a particular benefit or not. That is true for all of health care, that you might have coverage for bypass surgery, but a plan may decide whether to provide that based on certain criteria or not.

The main intention of this was to provide flexibility for a plan, to provide the array of services in a comprehensive manner for an individual in a way that is best fit for that plan and those individuals.

Again, as far as whether that is interpreted to mean whether the plan has discretion to provide that sort of option at all is one of those areas that are being reviewed in the review of the language for consistency. It is clear, though, that a plan should have the flexibility to decide who and when these offsets of trade-offs are used.

Senator WELLSTONE. My concern would be that if plans have this kind of flexibility of essentially denying someone the ability to make this exchange, then what you are going to get is a tremendous variation by where someone lives, by geography, and you are going to get these different tiers of plans. And I also think you would create an adverse selection toward the more generous plans and drive costs up. So I see a real potential problem here, and I wonder whether you have the same concern. Do you understand the question that I am raising?

Dr. ARONS. Yes, yes, I do. I understand, and I think there is a concern about adverse selection in any event, no matter what the coverage is, that there will be some plans that may get a reputation for or may in fact be providing better services for a particular condition than other plans, and then individuals with that condition might flow to those plans. The same thing is of concern to those individuals who are concerned about the treatment of individuals living with AIDS, that there might be a certain plan that just has a better array of services or more sensitive providers. That certainly could be true in the area of mental health and substance abuse as well.

There will need to be activities in the purchasing alliance, in the health plans, to address this issue. There will need to be opportunities for risk adjustment, for adjusting what a plan gets paid based on the sorts of individuals and what the intensity of those services are.

In addition, we feel that it is very important that monitoring and quality assurance be an essential part of this program.

Senator WELLSTONE. My final point—and I do not want to belabor it, because when I have you here testifying, I feel like I am talking with someone who has a lifelong professional commitment to the very best possible mental health care—but earlier in your testimony, you stated that you thought that this swap was really quite important. You emphasized that this flexibility would be there. And it is one thing to have flexibility as we do case management, but it is another thing if you in fact think this is very important and would enable people to do a little bit more on outpatient. Some people would argue with that, I know. But if you think that

it is, then it seems to me you would not want to make this something that would be up to the discretion of any individual plan.

That is the contradiction that I see. I mean, if you attach a considerable amount of significance and importance to it, then why build in an incentive for some plans to not allow those people who are in the plans to be able to do this. If you put the alliance in the position of monitoring this, don't you create the very incentives for more bureaucracy and regulations to make sure there really is not any discrimination or abuse?

I do not think we ought to make this optional.

Dr. ARONS. Mr. Chairman, the challenge that I think we all face is how to move from the existing system, a system that has a division between the public and private provision of care, mental health and substance abuse, and within the private insurance-based coverage, still an extensive fee-for-service array of services; how to move from the existing system to a future in which the management of the benefit takes the place of the existing limits and the existing prohibitions on length of treatment and cost per year and so forth.

It is the sense that what is written in the bill makes that transition possible by providing a financial incentive to provide a less costly and greater range of services, and at the same time not make that leap so quickly that under-treatment becomes a significant risk that we are not ready to face just yet, because of a lack of treatment guidelines and a lack of consensus in the field.

So this was the thinking about that question.

Senator WELLSTONE. Yes. And I do think there are all sorts of questions, some of which we are going to look at, about the transition and the importance of being careful about that.

Let me just conclude by saying I thank you for your testimony. We have had figures—and this is just my recollection—on the amount of dollars per covered life, the per capita expenditure, of anywhere from \$240 to \$380, and I think those of us who are very committed to this part of the health care plan are very concerned about this variation, and the sooner we can get a figure from you, the better off I think all of us will be.

And I very much appreciate what I think I heard you say. I asked some people today—which necessitated my doing a lot more work this weekend on numbers and technical points than I usually do—to come in here and try to speak to some of the actuarial assumptions and some of these numbers, because I think that is the critical point. And I think they have some new and important data. And I take what you said in very good faith, that you are willing to work with us and consider some of their projections, and go over our figures together. Am I correct?

Dr. ARONS. Absolutely, absolutely.

Senator WELLSTONE. Because that is critical.

Dr. ARONS. It has been a true privilege to work with you and your staff over these months, and we look forward to continuing that process.

Senator WELLSTONE. Thank you very much, Dr. Arons. Thank you for being here.

Dr. ARONS. Thank you.

Senator WELLSTONE. I will now call forward our next panel, which consists of Dr. McArdle, Dr. Frank, Dr. Docherty, and Dr. Crowell.

I thank each and every one of you for being here today, and I think that I will introduce the panelists as we go one-by-one, and then I will wait and ask questions of all of you, if that is all right.

Frank McArdle is with Hewitt Associates, which has a wealth of experience working with a lot of the larger companies, and he will speak to the pricing of mental health and substance abuse benefits in the health care package.

Dr. McArdle, I thank you for being here. I feel a little intimidated with all doctors. I try to get by—I am a doctor, but nobody cares, because it is political science.

STATEMENTS OF FRANK McARDLE, MANAGER, RESEARCH GROUP, HEWITT ASSOCIATES, WASHINGTON, DC, ACCOMPANIED BY DALE H. YAMAMOTO AND DR. JOHN J. MAHONEY; DR. JOHN P. DOCHERTY, CLINICAL PROFESSOR OF PSYCHIATRY, TUFTS UNIVERSITY, BOSTON, MA; RICHARD G. FRANK, PROFESSOR OF HEALTH ECONOMICS, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD; AND ARETA CROWELL, DIRECTOR, LOS ANGELES COUNTY MENTAL HEALTH DEPARTMENT, LOS ANGELES, CA

Mr. McARDLE. Well, I brought another doctor along with me, Dr. Jack Mahoney, who is a psychiatrist and has been working in the managed mental health programs that we have been working with in the private sector, and also our numbers cruncher, Dale Yamamoto, who has worked on many of the numbers that we are going to be talking about this afternoon.

As you said earlier, we are a firm that works with Fortune 500 companies, and we have been in business for over 50 years. We are here today not representing anyone but ourselves. We are not lobbyists, and we are thankful for the opportunity, though, to share our professional opinions with you about the preliminary assessments of the President's plan and to illustrate what we think is probably the most important principle, which is that the costs of the benefit are going to vary dramatically with the plan design.

What we bring of particular value is a database that has some 8 million lives in it, and through this database we can capture the experience of the latest generation of managed mental health programs, and these kinds of datasets are typically not available to the Government actuaries and the public sector analysts. But they are worth your attention because these kinds of programs can allow you to deliver more generous benefits at the same or reduced cost, and they do this by reducing utilization, by resolving problems with short-term interventions, and by directing patients to the most appropriate providers.

The kinds of savings you can see in these programs are really very dramatic. In an aggressively managed program, we can see first-year reductions of 25 to 35 percent. And we have one case study where over 2 years, the costs dropped by 67 percent, and they continued to drop thereafter.

Let me make it clear that when we talk about managed programs, we are not talking about HMOs. HMOs budget a low flat

fee per enrollee, and they have a financial incentive in effect that may deny care on occasion. What we are talking about is managing care through true case management, beginning with the intake session and then following these individuals through their service with providers, many of whom accept discounts.

But this kind of plan costs more than a typical HMO budgets for managed mental health. HMOs will budget about \$5 per member per month, whereas the cost we are talking about is at least twice that amount.

As Dr. Arons explained to you, the numbers around the administration's proposal are still subject to change, so we cannot give you a final answer about how much the benefit will cost, but we can give you some preliminary assessment, and we would like to do it in two ways. We would like to take the benefit and assume what it would cost if it were totally unmanaged, which is the situation Dr. Arons said they are worried about, and then also look at it as if it were managed the way we would structure it for a large employer.

We have these numbers in our testimony, and I have also given you a chart, which may be a little easier to follow. But we have also had to make some assumptions here, because as you pointed out in your questioning, there is lots of discretion in this plan, so as an actuary, you have to make some guesses about how many additional visits to permit, so we have made these kinds of assumptions, and we have tried to do it in a way that is conservative so that we do not underestimate the cost. But clearly if we change the assumptions or you change the level of discretion, these prices could go up or down depending on the changes that you make.

But we found that the plan, if it were totally unmanaged, would cost about \$225 per individual; that is the first bar that you can see on the chart. By contrast, if we put that in a fully-managed but low cost-sharing plan, the cost drops down to \$175 per individual. So you can see that there is a dramatic difference that varies with the level of management.

Now, your staff also asked us to go a couple of steps further and say what would happen if we improved the outpatient benefit; those are the other numbers that you see below here. And basically, if we went all the way up to the richest, which is 80 percent benefit for unlimited number of visits, the cost would rise by about \$40 per individual, to \$265 in an unmanaged plan, but to \$200 in a fully-managed, low cost-sharing plan.

So you can get a sense here about the opportunities there are. So even though the numbers are going to change, the lesson is the same, and the lesson is that the cost is going to vary dramatically with the benefit design.

There was also some talk about capacity and how much capacity there is. We would agree that capacity does not exist everywhere in the United States, but it is much more prevalent than people in Washington often think. Last year, there were nearly 80 million people enrolled in some kind of managed behavioral health program. These are not all the kinds of programs that would be our first choice, but it is still a huge population that is out there.

Second of all, we think capacity could be created rather quickly. Universal coverage under the President's plan would not kick in

until 1998, so we have at a minimum 4 years to work all that. And it is not a question of starting from scratch. It is not like creating new primary care providers. It is more a question of creating management capacity.

The subject of limits has also come up. The data in our database which we have shared with you shows that most large employer plans do have annual limits on inpatient and outpatient care. And the Clinton plan has limits as well. But still, many employees, if they have to get their coverage through the standard package under a regional alliance—and most employees would—those with richer benefits stand to get a benefit cut. Now, it probably does not make sense to force that to happen. Instead, it probably makes more sense to let people keep their current plan if it is equal to or better than what would be in a regional alliance standard package.

The Health Security Act also has provisions for treating families, and we think those are very wise. Jack, my colleague, actually co-authored a study where the companies saved more on dependent medical claims than they did on employee claims with the managed mental health program. So the fact that this illness is felt by the family is a very important cost factor as well.

Just to wrap up, we think that tools do exist to offer a managed mental health benefit and to control its costs. These can allow individuals to receive better benefits and, with the proper standards, set by Congress or by a national health board, standards for those who manage the care, the quality might be quite good and even improved.

Thank you, Mr. Chairman.

Senator WELLSTONE. Thank you very much, Dr. McArdle. I have four or five I hope you will think significant questions for you, and I will come back to you. I think we will just go forward with the panel and then all of us can engage in a discussion and zero in on any number of different points that I want to have on the record today, that I want to be a part of where we are heading.

Thank you.

[The prepared statement of Mr. McArdle follows:]

PREPARED STATEMENT OF FRANK B. MCARDLE

Mr. Chairman and Members of the Committee, my name is Frank McArdle. I am a consultant with Hewitt Associates, and I manage our firm's Research Group based here in Washington, D.C. I have been working in the field of public and private benefit programs for more than 17 years. In fact, during my prior career with the Senate Special Committee on Aging, I spent a great deal of time in the oversight of the Social Security Administration's reviews of the mentally disabled and in the crafting of remedial legislation. So I am especially sensitive to definitions of mental illness that find their way into the law and how they can be turned and twisted in opposite directions.

With me today are Dr. Jack Mahoney and Mr. Dale Yamamoto of Hewitt Associates. Jack is an M.D. and a M.P.H., a physician with broad experience in the fields of psychiatry, addiction medicine, and public health, who has been very active in the design of the latest generation of managed mental health programs in the private sector. He is based in our Connecticut office. Dale is our chief health care actuary working out of our national headquarters in Lincolnshire, IL.

Hewitt Associates is an international consulting firm specializing in the design, financing, communication, and administration of employee benefit programs. We provide consulting services to over 75 percent of the Fortune 500 companies and have an active client base of over 2,000 employers. We have been in business for

more than 50 years, and employ more than 3,500 associates in most of the states represented by this Committee.

We are honored to be here today. The subject of this hearing is one of the most difficult important ones you will have to address as part of national health care reform. To his credit President Clinton urged us all to engage in a constructive debate of his proposal and to be honest about those areas where we, collectively, don't have the answers.

We at Hewitt Associates do not represent anyone here today except ourselves. We are not doing work for any provider groups. We have no direct business interest in any managed mental health vendor relationships. We are not lobbyists or lobbying. But we do have an interest in sound public policies regarding the standard benefit package under health care reform, and we welcome the opportunity to share our professional expertise with this distinguished Committee.

What we will do today is draw upon our experience in designing mental health programs for large employee populations to give you some preliminary reactions to the design of the President's proposed mental health benefit; sketch out for you how we ourselves would go about designing such a package for a large employer; and illustrate for you how the costs of the benefit are dramatically affected by the particular design of the program.

Our remarks about cost in relation to the President's proposal are necessarily preliminary because we do not have all the information we would like to truly cost out that design on a national basis; and because as we understand it, the proposal itself is undergoing refinement in technical areas that could significantly affect cost. So we do not have the "answer" about how much precisely this program will cost, but we can estimate for you how much it might cost if it were applied to a large employee population (as opposed to the currently uninsured and permanently disabled).

Where we particularly add value is through our large private database and extensive experience in designing cost effective, high quality programs. Our actuarial model is based on data from our claims database of private employers' experience for active employees. Our current claims database includes data from employers that accumulate to eight million life years of experience. This data was supplemented by the actual, hands-on experience of our leading mental health consultants and actuaries, like Jack and Dale, who have helped large employers control costs through the introduction of managed mental health programs. With this model, we can determine the cost impact of changing both the plan design and the delivery of managed health benefits.

The experience of this latest generation of managed mental health plans will not be captured by the older, historical data sets and academic studies typically available and used by government actuaries and policy analysts. But we do have extensive experience with such programs and they offer some very positive opportunities for the Congress in designing mental health benefit options.

Health Security Act

Over the last several months, we have observed the careful consideration and internal debate the Administration has given to its proposal. In fact, we notice significant differences between the mental health benefit as described in the preliminary 239-page draft specifications of early September, relative to the legislative language released by the President on October 27, 1993.

Many of these differences reflect design improvements, in our opinion, and they strengthen certain broad concepts that would be very helpful in designing a national mental health benefit.

For example, the Health Security Act would cover inpatient and outpatient mental health and substance abuse treatment, as well as less restrictive and less expensive alternatives to inpatient hospitalization. The earlier version had a reimbursement bias that favored inpatient hospitalization but the recent legislative language attempts to correct for any such bias by:

- Limiting coverage to the least restrictive inpatient or residential setting;
- Giving the health plan the discretion to cover usually less expensive, intensive nonresidential treatment;
- Allowing for substitution of 2 days of intensive nonresidential treatment for each day of inpatient treatment; and
- Allowing for the substitution of 4 outpatient visits for each inpatient day if it would cut down or eliminate more expensive hospitalization.

In other words, the Clinton proposal sets limits on what will be covered, as do more than 90% of large employer plans. But it does so in a way that attempts to

give plans maximum flexibility to substitute more effective treatments and it provides for ways to override the limits where there is a medical necessity to do so.

Hewitt Associates maintains an extensive database on benefit plan provisions. We have information on the mental health and substance abuse programs for 1,033 of the employers in the database. The data represents plan provisions from 564 indemnity plans (fee-for-service), 371 preferred provider organizations (PPO), and 98 point-of-service (managed care) plans. The following two charts summarize the special limits under mental health and substance abuse provisions of these plans.

Inpatient Limits

	Percent of total
No special limits	7
Limits for both MH and SA	82
Special limits for MH only, no SA limits	2
Special limits for SA only, no MH limits	6
Other (e.g., limit for MH and SA not covered)	2
Not covered	<1
Data not available	<1

Outpatient Limits

	Percent of total
No special limits	4
Limits for both MH and SA	87
Special limits for MH only, no SA limits	5
Special limits for SA only, no MH limits	1
Other (e.g., limit for MH and SA not covered)	3
Not covered	<1

This data indicates that most employer plans are in line with the proposed Health Security Act provisions which limit both mental health and substance abuse services.

Even with all this flexibility, however, you should recognize that very many employees, particularly those with large employers or in union plans, will have more generous mental health benefits than the Health Security Act provides. These employees would suffer a benefit cut if they were required to obtain their coverage through the regional alliance, which most would do as the plan is written. Fortunately, there's an option to "fix" this problem, if the Congress were to incorporate a provision that Senator Kennedy and others had included in their earlier versions of mandatory health insurance: actuarial equivalence. In other words, if current employees are receiving medical benefits that are actuarially equivalent or better than the standard benefit package under the Health Security Act, it makes little sense to force them to undergo a benefit cut or to restructure the plan into a basic plan and a supplemental plan that will not necessarily replicate what they have now. It would be particularly difficult to supplement the coverage differences in the mental health/substance abuse benefit because of the limits on covered days and visits. In those situations where the current coverage is equivalent to or better than the standard package, employers should be permitted to continue offering that current plan.

Another good feature of the Clinton plan is that it allows for the coverage of case management, meaning the services that help individuals gain access to needed medical, social, educational and other services. This can be a very cost-effective way of directing patients to the needed services. Coupled with the coverage it provides for screening and assessment and crisis services, these features of the bill allow for a plan that is set up to intervene early in the episode of care and to mix and match the most effective combination of services. This treatment flexibility is extremely important to a truly cost effective program. We have found that merely limiting the number of outpatient visits or severely limiting the coverage for mental health or substance abuse has proven to be a short-sighted approach, producing some short-term savings without the appropriate treatment. The results tend to be high relapse and recidivism rates, with employees reentering the system on multiple occasions for the same condition, ultimately compounding the long-term cost problem. As an

alternative, managed mental health/substance abuse treatment is clearly, in our opinion, the most cost-effective long-term approach.

In other words, using a state-of-the-art managed mental health plan design can result in substantially improved benefits for participants at the same or reduced cost. This is accomplished by reductions in inpatient and outpatient utilization, by resolving many individuals' problems with short-term interventions, by directing the longer-term, more serious treatment to appropriate providers, and by negotiating discounts with providers.

Finally, the Clinton plan recognizes that the impact of mental illness and substance abuse is felt not only by the individual concerned, but also by the person's family. And it would provide for the coverage of additional collateral services for the family members, for up to 30 visits of outpatient treatment. To illustrate the importance of this family treatment orientation, consider the results of a study for the McDonnell Douglas Company, designed and coauthored by my colleague Jack Mahoney. It found that the provision of managed mental health services saved even more on dependent medical claims (\$3 million over 4 years) than its considerable savings in employee claims (\$2.1 million).

We would also like to be clear about our use of terms. As far as the quality of care is concerned, we have noted a tendency to define "managed mental health care" as care provided through Health Maintenance Organizations (HMOs). We would like to emphasize you that in our experience, the quality of care provided through a managed mental health program can be superior to the average HMO's capitated approach. HMOs are paid a low flat fee per enrollee, and they "manage" mental health and substance abuse by adopting a system of benefit design or utilization decisions that may, in effect, deny care; and certain poor outcomes, especially for the more serious or chronic conditions, have been documented by some recent studies.

In contrast, most of the major mental health and substance abuse vendors manage care through true case management, beginning at the intake session, and they couple this utilization monitoring with discounted fee-for-service payments to providers. This allows for more appropriate and better quality treatment, but it costs more than HMOs typically spend for mental health care. The typical HMO targets a budget of approximately \$5.00 per member per month for mental health and substance abuse spending (the actual number reported by InterStudy in 1989 was \$2.69). This level of HMO spending is lower than the cost per covered life in the managed mental health programs we are describing, which is about twice as high. Thus, the managed mental health programs save money long-term by making more effective use of resources, not by denying care in the short-term.

How Hewitt Associates would structure a plan

Our observations about three cardinal aspects of behavioral illness are useful to restate, prior to discussing the structure of a mental health plan.

1. Mental illness and substance abuse are often chronic and relapsing. While mental illness and substance abuse typically present themselves as acute conditions, in fact, the length of illness, or chronicity, is usually considerable. Studies conducted in the workplace have shown that individuals with these conditions often have evidence of impaired performance (absenteeism and increased use of health care resources) lasting from two to five years. The impairment may exist for a year or more before the affected person is no longer able to function and seeks professional assistance. That marks the beginning of the acute phase of treatment, which may take anywhere from a few weeks to many months, depending on the severity of illness, availability of resources and the appropriateness of the care given. With the exception of some minor conditions, treatment does not cease at the end of the acute phase. The person will require additional support and/or monitoring services to resume normal daily tasks successfully and be productive. The sources of support include both mental health professionals and immediate family members. In some instances, especially with substance abuse and psychoses, there is a high probability of relapse that may precipitate yet another period of acute treatment.

These conditions affect entire families. The person with a mental illness or substance abuse has the potential to impact the physical and emotional health of co-workers and, most importantly, the person's immediate family. Again, workplace studies demonstrate a clear relationship between an individual family member being treated for a behavioral illness and increased medical claims costs for an entire family. These increased costs are commonly ascribed to physical conditions but may also be for behavioral health care.

Behavioral illness frequently coexists with other medical conditions. Persons with these conditions typically seek medical assistance for a wide range of physical problems. These may be directly or indirectly related to the behavioral condition. For example, a person with depression may have a wide array of "ill-defined" physical

complaints ranging from headaches to indigestion. There is a high probability that, absent intervention by mental health professionals, treatment for these secondary or associated physical conditions may continue for prolonged periods. Appropriate, effective treatment of the underlying substance abuse or mental illness can produce prompt resolution of both the behavioral problem as well as the physical condition. This is frequently referred to as the "offset effect". While mental health practitioners are well acquainted with this phenomenon, we know of no study which firmly documents the exact magnitude of this offset on a national scale.

Given this knowledge and these observations, we would recommend the following structure.

Access

We would recommend a minimum of financial and structural barriers to access care. Experience gathered in the workplace by Employee Assistance Programs (EAPs) has taught us the value of prompt, appropriate treatment delivered early in the progression of a mental health or substance abuse condition. When addressed at this early stage, many problems (approximately 60%) can be resolved in no more than six outpatient therapy visits with the appropriate therapist. We believe such access is potentially available under the Health Security Act with the inclusion of screening, assessment and crisis services to be provided by all health plans. We would caution that to be effective, it is especially important that these services must be provided by persons who are specifically trained and have practical field experience. They should be professionals in the areas of social work, psychology, nursing or medicine and have special training in the area of substance abuse.

Treatment Resources

Effective treatment under the plan should not be biased toward over-extensive use of inpatient facilities. Effective treatment is more dependent on a vast array of treatment modalities and professional skills. In most instances, these are best delivered in the outpatient setting. Therefore the language in the Health Security Act which encourages treatment in the least restrictive treatment setting is extremely useful, as is the ability to "swap" inpatient treatment days for outpatient treatment sessions. It would be better, however, if the discretionary element were narrowed by appropriate treatment protocols, or some other mechanisms to ensure that discretion results neither in the routine denial of the care or in excessive utilization. The issue also has to be faced that there may be situations where individuals have exhausted their inpatient visits via the "swap," and later find that they are in desperate need of inpatient care nonetheless.

For those individuals who truly require inpatient care, the provision of 30 inpatient days per episode, with the option of additional days if deemed necessary by a "designated health professional," is adequate. This said, we have concerns regarding the role of this "designated health professional." In current practice, decisions regarding appropriateness, or medical necessity, are made by a wide range of persons who are said to fit this description. The result, as we all know, produces marked inequities in care. We strongly believe there should be a uniform set of criteria promulgated by the National Health Board to guide the decisions of these health professionals.

Care must continue to be delivered after the acute treatment ends. Typically, this is a series of outpatient visits which are structured to meet the individual patient's specific needs. This could be accomplished through use of the Health Security Act's outpatient benefit or through "swapping" inpatient days for outpatient treatment visits.

Treatment must be available to persons who have a relapse or recurrence of their condition. Limitations on the number of treatment episodes are typically ineffective. We believe this is possible through the present language in the Health Security Act. However, we would raise the same cautions mentioned earlier regarding the role of the "designated health professional" in assuring equity in application of this provision.

Collateral services

We know that the "target" patient, as well as his or her family, requires attention and treatment. We would suggest the inclusion of collateral care services, as the Health Security Act does.

Case management

The availability of all of these services is not enough. They must be orchestrated and coordinated. In our experience, this case management function is essential if the individual is to receive appropriate and effective services at an acceptable cost. It is this management function which has led to the success of managed mental

health services in the workplace. We are pleased to see this service included in the Act but would suggest that it might be more effective as a mandatory service provided by all plans. Employers who have "carved out" the mental health and substance abuse care from the benefit plan and applied specialized clinical skills and utilization/cost methods report great success in controlling cost and improving quality. Very dramatic decreases in cost have been reported, though the results can be quite variable across companies.

Cost of managed mental health benefits

As an illustration, Hewitt Associates has used our actuarial model to give a preliminary price of the plan the Administration is currently recommending for coverage of mental health and substance abuse benefits. (The pricing can be more final after the Administration has made its additional technical refinements and after certain clarifying assumptions are made about how the plan provisions are to be applied in many gray areas of interpretation.)

After illustrating the cost effects, we would also like to address some of the concerns that have been expressed with respect to service capacity.

Costs and utilization

The description of benefits payable under the Health Security Act and their inter-related limits on services is not a typical design of current employer plans. As such, we have taken liberty make "conservative" interpretations of the provisions to fit our standard actuarial pricing model. These assumptions are described in a later section of this testimony. (Modifications of those assumptions would naturally raise the pricing to varying degrees, so Congress would be well advised to introduce as much precision as possible in defining its intent.)

We have taken the approach of developing costs for the Health Security Act plan provisions based on two different scenarios for managing the same covered services: First, we priced an "unmanaged" plan at \$225 per covered life under the high cost-sharing plan in 1994. Then, we priced a managed plan at \$155 per covered life. The estimated cost under the low cost sharing plan is \$175 per covered life. The low cost-sharing plan cost assumes the same level of utilization savings and discounts as the managed high cost-sharing plan. These costs are based on claims data provided to Hewitt Associates from large employers in the United States. We have not attempted to adjust these costs for the potentially different utilization experience of the non-working or the uninsured populations.

If we took the 50% outpatient benefit and increased the benefit to 80%, the cost per covered life (in 1994 dollars) would rise to \$250 under the unmanaged high cost-sharing plan; \$175 under the managed plan; and \$185 under the low cost-sharing plan. If we made the outpatient benefit unlimited visits at 80% coinsurance, the cost would rise to \$265 under the unmanaged high cost-sharing plan; \$190 under the managed plan; and \$200 under the low cost-sharing plan. This cost is close to what the mental health benefit would cost (in 1994 dollars) in the year 2001, when the benefits are scheduled to increase under the Health Security Act.

Hewitt Associates does not keep a database on the uninsured population's medical costs, and there is uncertainty and disagreement about how much additional mental health benefits the uninsured population might be expected to use, when they receive coverage. If one assumes (as some studies have found) that the uninsured population would cost 20% more than the currently insured population, and if 15% of the population is uninsured, then the additional cost per covered life would be 3% higher than the figures we have provided above. That additional cost, however, does not reflect total public and private spending for the severely mentally ill.

Most importantly, these scenarios provide an indication of how different the resulting cost can be under the same level of plan design but under different levels of managed care.

Plan design

In addition to pricing both the high cost-sharing and low cost-sharing model of copayments and coinsurance, we have also included the following limits on care for mental health and substance abuse services, as based on the Health Security Act.

60-day inpatient limit (assumes that the full 60 days are available to an individual and that the 30-day per episode limit can be manipulated).

120-day limit on intensive nonresidential treatment (one-day reduction in inpatient for each two days nonresidential for first 60 days; and 60 additional days if medically necessary).

One-day inpatient deductible for each episode of inpatient and residential mental health and substance abuse treatment.

30 visits outpatient psychotherapy (additional discretionary visits allowable assumed to be offset by cost savings in reduced inpatient days at one day for each four visits) and 30 visits for collateral services.

20 percent coinsurance for inpatient and residential treatment and 50 percent (20 percent in the year 2001) for outpatient psychotherapy and collateral services.

Deductibles, copayments and coinsurance for outpatient mental health and substance abuse benefits apply to overall out-of-pocket maximum of \$1,500 individual and \$3,000 family in the year 2001. Annual limits are also removed in 2001.

We have also assumed that standard insurance industry reasonable and customary (R&C) fees will be allowed as a covered expense and that there are no maximum dollar limits on any service (outside R&C limits).

Utilization savings

The degree of savings achievable by the different levels of managed care can be very dramatic. In a moderately managed program with a utilization review plan that monitors all mental health and substance abuse treatment and directs appropriate care on an as needed basis, overall costs are reduced from five to ten percent (most of which is coming from inpatient costs).

Under a program with a well-managed employee assistance program and utilization review with preferred discounting, an employer can expect total reductions of 30 to 40 percent on inpatient costs and 10 to 20 percent on outpatient costs. Overall costs may be reduced in the range of 25% to 35%.

We have reflected both anticipated utilization and provider discount savings in our cost estimates. The costs provided in our testimony are based on the claims experience of large employers. It does not include data on the currently uninsured and non-working population.

We have assumed the following utilization savings and discounts under the two scenarios:

	Unmanaged	Managed
Inpatient utilization	0%	30%
Inpatient discounts	0%	25%
Outpatient utilization	0%	0%
Outpatient discounts	0%	20%

In addition, we have also anticipated higher administrative costs (e.g. \$30 per covered life per year) under the managed care scenario to reflect the costs to run a provider network and provide assessment, referral, ongoing review and management services.

Managed mental health case study

In our experience, there are many case studies that can be reviewed to substantiate the assumptions chosen in our analysis. The following provides highlights from one company who began implementing varying forms of managed mental health benefits in 1987.

In one location, they observed an overall 67 percent reduction in costs in the first two years of the program. The costs have continued to decline at an average rate of 13 percent per year. First year reductions were similar at two other company locations.

The admission rates for locations adopting the managed program decreased by 45 percent, on average, between 1990 and 1992. Other locations that did not adopt the managed program increased 17 percent during the same time period.

Certainly upward adjustments in the cost of all these plans should be made to reflect new pools of uninsured individuals. Still, the overall cost relationships are roughly the same. In fact, we would expect the managed mental health plan design to compare even more favorably to the indemnity plan where the pool of enrollees includes relatively more high users of mental health benefits.

Managed mental health service capacity

When the subject of managed mental health comes up in Washington, we sometimes hear comments about the current limitations on service capacity for a nationwide system of managed mental health care and concerns about the quality of care provided through managed care organizations.

While we would agree that the service capacity does not yet exist nationwide, we have found that it is much more extensive than government policymakers often

think. Already there are approximately 30 large vendors supplying these services nationally, and hundreds more operating on a local or regional basis. In 1992, there were more than 78 million people enrolled in managed behavioral health care programs, "behavioral health" being a catch-all term including mental health and substance abuse. These programs consist of behavioral health PPOs, utilization review and case management, and EAPs.

We also would think that the capacity would continue to grow quickly under the Clinton Administration's plan to promote integrated systems of care through regional health alliances. The current design of the benefit also would create financial incentives to hasten the development of managed mental health care. The "managed mental health plan" could be offered, provided it is "certified" as having the appropriate vendors and medical providers with credentials. Standards for certification could be established by the Federal Government. (We have already developed criteria that large employers use to select a high quality vendor.) Where such "certified" plans do not exist, participants would start to demand them (because they would get better mental health benefits), and providers would want to supply them (again, because they allow for more flexible and appropriate treatment patterns and schedules). So where we start out with no certified plans, we would quickly move toward them, given the financial incentives created by the existence of the managed mental health plan option.

We are finding that mental health and substance abuse treatment providers have begun to actively seek out opportunities to join major managed mental health networks. In part, their motivation is one of economics. As we have seen, the managed mental health networks control vast numbers of individuals, many of whom are the providers' own existing patients. In some cases, survival dictates joining the network to keep the patient. In other cases, providers will join the network out of consideration for their existing patients, who will receive higher reimbursement if the provider joins the network.

The practical experience of the network providers has also become quite good. For example, we just did an on-site audit of a managed mental health network for a large employer. We pulled, at random, 40 provider files, to check references and credentials. Of these 40, only one had less than five years of experience in the field. The remainder had a minimum of 10 years. One psychiatrist had 25 years of experience.

Also, we would point out that this service capacity would not be created from scratch. It is not a question for managed mental health programs of creating additional provider capacity, as there is for primary care, for example. Instead, what needs to be created is management capacity. The development of such capacity could also be fostered by the regional purchasing alliances, who might even, as a transitional device, develop outside management capacity that could serve all the plans within the alliance who choose to take advantage of it.

Conclusion

The Health Security Act contains many positive concepts for the design of a mental health benefit program. We have tried to describe how we would take those components of a good system and structure them into a cost-effective program. Lots of questions still require answers, notably, what the costs would be for the severely mentally ill and the short-term and long-term utilization of mental health services by the currently uninsured population. Still, the current environment allows the Congress to address the critical need for mental health and substance abuse services and to control its cost by creating incentives to manage the care in a cost effective, high quality mode. National health care reform legislation should include a managed mental health benefit alternative along with the indemnity plan option. The principal reason is that current, state-of-the-art managed mental health plan designs would allow health plans to offer plan participants more generous benefits at a relatively lower cost. And if the proper standards are set for those who manage the care, quality may be improved.

APPENDIX

The following represents data from 150 randomly selected companies in the 1993-1994 Hewitt Associates' SpecBook™ (1,034 employers total).

INPATIENT LIMITS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

No special limits	8%
Limits for both mental health and substance abuse	84%
Special limits for mental health only, none for substance abuse	1%
Special limits for substance abuse only, none for mental health	5%
Other (e.g., limit for mental health, substance abuse not covered)	1%
Mental health and substance abuse not covered	1%

OUTPATIENT LIMITS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

No special limits	4%
Limits for both mental health and substance abuse	85%
Special limits for mental health only, none for substance abuse	6%
Other (e.g., limit for mental health, substance abuse not covered)	4%
Mental health and substance abuse not covered	1%

LIFETIME DOLLAR OR DAY/VISIT MAXIMUM

Inpatient mental health	65%
Inpatient substance abuse	67%
Outpatient mental health	47%
Outpatient substance abuse	47%

ANNUAL DOLLAR MAXIMUM

Inpatient mental health	19%
Inpatient substance abuse	18%
Outpatient mental health	59%
Outpatient substance abuse	54%

ANNUAL DAY/VISIT LIMIT

Inpatient mental health (median=30 days)	
<30 days	10%
30 days	44%
>30 days	46%
Inpatient substance abuse (median=30 days)	
<30 days	11%
30 days	49%
>30 days	40%
Outpatient mental health (median=50 visits)	
<30 visits	21%
30 visits	12%
>30 visits	67%
Outpatient substance abuse (median=50 days)	
<30 visits	22%
30 visits	7%
>30 visits	71%

COINSURANCE

	Inpatient		Outpatient	
	MH	SA	MH	SA
50%	1%	1%	33%	23%
60%	1%	1%	1%	1%
70%	3%	3%	2%	2%
75%	1%	1%	1%	1%
80%	60%	57%	28%	35%
85%	3%	3%	--	1%
90%	21%	22%	10%	11%
95%	1%	1%	--	--
100%	4%	4%	8%	9%
Declining scale	4%	6%	16%	13%
Not covered	1%	1%	1%	4%

COPAYMENTS

Inpatient mental health	1%
Inpatient substance abuse	2%
Outpatient mental health	12%
Outpatient substance abuse	11%

COVER NONRESIDENTIAL TREATMENT

Data not available

SUBSTITUTE INTENSIVE NONRESIDENTIAL FOR INPATIENT

Data not available

Senator WELLSTONE. Dr. Docherty? And one more time, for those of you who may have come in late, Dr. John Docherty is clinical professor of psychiatry at Tufts University in Boston, MA.

Dr. Docherty, thank you for being here.

Dr. DOCHERTY. Thank you, Senator Wellstone. Good morning.

I am grateful for the opportunity to address the panel today and am very appreciative of your attention and concern in taking the time to address the alleviation of the suffering of this Nation's mentally ill.

I speak to you today as a private citizen. My gratitude and appreciation for your time derives from my 23 years of work with the mentally ill as a psychiatrist and from the fact that my father, whom I deeply loved, suffered from a serious mental illness. I do hope I can bring some useful perspective to this panel based on my experience in psychiatry, which has been in academic, private, State and Federal Government settings and in work as a clinician, administrator and researcher.

In the United States today, we have properly become concerned with the lack of access to care of millions of Americans. This problem, as terribly serious as it is, pales in comparison with the specific lack of treatment of the mentally ill.

In the United States, we have what I would regard as a national disgrace. Simply put, we do not treat our mentally ill. The National Institute of Mental Health Epidemiological Catchment Area Study, the Nation's major study of the prevalence of mental illness, found that less than 50 percent of those patients with schizophrenia received any care within a 6-month period, less than one-third of those with major depression, less than 25 percent of those with anxiety disorders, less than 15 percent of those with chemical dependency problems, and less than 10 percent of those with organic brain syndromes, that is, problems such as dementia.

Treatment in this context is defined as contact for a mental health problem with any kind of provider over that 6-month period of time. That is a single contact. In Georgia, the director of child and adolescence services in that State's department of human resources indicated last year that she was able only to provide care for 18,000 of some 90,000 children who are severely emotionally disturbed and needing help.

Such neglect of our mentally ill is not tolerable in an advanced society. One of the sources of this grave social problem is an insidiously persistent prejudice we harbor against the mentally ill. While this attitude may have been understandable in an era when the nature of mental illness, its biology, and the psychology and social forces creating it and affecting it were not understood, it makes no sense any longer; yet it persists.

A Rand Corporation national study of medical practice patterns found, for example, that less than 50 percent of patients suffering from major depression were likely to be accurately diagnosed on a visit to an internist or general practitioner.

Another recent study on 33 patients who were found after angiography to have normal heart vessels further found that 20 of these patients were suffering from panic disorder symptomatology, a psychiatric disorder that can mimic certain cardiac symptoms, al-

though when an entire history is taken, it is clearly diagnosable in and of itself.

This lack of appropriate diagnoses for two major disorders is a reflection of the pervasive lack of understanding of mental illness in our society. It affects all of us, including primary care medical providers.

The cost of this neglect of the mentally ill is extremely high. We add enormous costs to our medical care system by failure to adequately treat the mentally ill. For example, it is estimated that the cost of the misdiagnosis and failure to treat panic disorder I just mentioned is responsible for 50,000 unnecessary cardiac catheterizations annually. The underdiagnosis of depression I cited is another excellent example. The depressed patient, who appears typically with physical symptoms such as weight loss and loss of appetite, improperly diagnosed may be subjected to numerous expensive gastrointestinal diagnostic procedures which are completely unnecessary. Do not forget—a general practitioner's visit with a patient amounts generally to about 10 to 15 minutes in time.

Furthermore, while all of this is occurring, the functional disability and its cost to work and family life persists and worsens. In addition, extra cost is added to the medical care system from so-called noncompliance, that is, patients not following their physicians' recommendations. For example, patients with hypertension not taking their medication, and patients with cardiac problems not following their diet programs. Such compliance problems are often the result of psychiatric disorders. The depressed patient simply does not have the energy or the cognitive wherewithal to follow a medical program.

The direct treatment of such disorders can considerably enhance the patient's motivation and capacity to become compliant, especially with a complex medical regimen, and thus decrease other medical care utilization.

A major large-scale study found that a conservative estimate is that 10 percent of overall medical costs would be reduced by an adequate psychiatric care system. It is estimated in a recent report published in the American Journal of Psychiatry that for the seriously mentally ill, an adequate system of care would actually cost less in overall health care costs because of the reduction in medical care utilization.

The cost of not treating the mentally ill is reflected in numerous other ways. These illnesses do not disappear simply because we choose to ignore them. For example, the Los Angeles county jail is now the largest inpatient provider of mental health care in this Nation. This trend is present across the country. This is astonishing considering our severe criticism of the Soviet imprisonment of the mentally ill in the not so distant past.

Senator WELLSTONE. Would you please repeat that one more time?

Dr. DOCHERTY. Yes. The Los Angeles county jail is now the largest inpatient provider of mental health care in this Nation. And it is not only in California that this trend is present; it is present throughout the Nation.

To expand on that point, several years ago, we in this country were very critical about the Soviet practice of imprisoning their mentally ill. We are de facto establishing a very similar system.

In addition, as a resident of California, during these past 2 weeks, my own home was threatened by devastating fire storms along the Southern California coast. Twice, I had to pack up all of my possessions and move them from my house. My experience was nothing compared to those 500 families who lost their homes and possessions. The single source of the greatest amount of this destruction was an itinerant homeless man building a fire to warm himself.

What price is our neglect of the homeless? I do not know at this point if this man was mentally ill, but based on the statistics we do have regarding the percent of mentally ill among the homeless, it is a high probability. The price we have paid for this single piece of neglect is enormous.

The saddest fact of all is that we are fortunately at a point in the history of the care of the mentally ill where we have available highly effective treatments to alleviate the terrible suffering and functional disability of these illnesses. Specifically for the mental disorders of schizophrenia, panic disorder, bipolar disorder, obsessive compulsive disorder, and major depressive disorder, our improvement rates vary from 60 to 80 percent. To get a sense of the magnitude of this effect, it compares with improvement rates of between 40 and 50 percent for angioplasty and atherectomy for cardiovascular disease.

Furthermore, with appropriate long-term treatment, psychiatric practice can reduce relapse rates—and this is extremely important in terms of a well-functioning system; it is not costly to provide this kind of care, but it is essential in terms of the well-being of the patient and the financial integrity of a system of care. With proper maintenance treatment, we can reduce relapse rates in schizophrenia from 80 percent over a 2-year period to just over 20 percent; in bipolar disorder from over 80 percent to approximately 30 percent, and in major depressive disorder from 70 percent to under 20 percent.

Furthermore, we are in the center of a wave of new knowledge that has developed over the last 2 decades in both basic neuroscience and psychological sciences that has the promise to usher in an entirely new era in the effective treatment of the mentally ill. All of this will be lost without the acceptance of our social responsibility to fully and completely care for all of our mentally ill.

The problem as I have presented it may appear vast. We have many people who must get access to the effective care we now possess. In addition, however, to knowing the specifics of individual treatment, we also know what the elements of dysfunction in our system are, and we know what the characteristics of an adequate system of care must be.

Furthermore, it is my own personal belief that there has been a strong definite shift in the implicit social mandate of medicine. This shift is from a mandate to develop new specific treatments for individual disorders to the development of a system that would provide better care for more people at less cost. Such a new system in the area of mental health care must ensure that the large body

of knowledge possess and the specialized skills of individual providers are woven together so that the particular patient gets proper care, competently delivered, by an appropriately trained clinician, in a timely and cost-conscious manner.

That is the goal of a well-functioning system of managed care.

Senator WELLSTONE. Dr. Docherty, I do not want to interrupt you, but you may have to finish up so I can make sure I hear from everyone and we have time for questions.

Dr. DOCHERTY. All right. Such an adequate system must be accessible, comprehensive, coherent and accountable. And I could expand on those particular issues.

I would like to close by saying that much of the dysfunction and distortions in our contemporary mental health care system result from reimbursement structures which make actuarial sense but not clinical sense—for example, very high copayments for outpatient care and low copayments for inpatient care.

I think we have some problems that require attention in the President's proposal, although I am very pleased with the administration's strong and vigorous support for the mentally ill and with the basic intent and direction of this proposal.

Two that I think need to be considered are the fact raised earlier about the uniform benefit plan, which I think must exist across all plans for the mentally ill. We cannot afford the adverse selection which has characterized our present system and the progressive deterioration in the benefit that is the result of that.

Second, I feel these plans must be required to provide for case management and for intensive outpatient care. I can expand on that in questions as well, but those services are absolutely essential for the public sector patient and to incorporate patients who would otherwise go into that plan.

Finally, I feel that we need a completely unlimited outpatient benefit at a 20 percent copayment. That is a minimal extra cost to the system given the nature of outpatient utilization, on which we have substantial data, and will also make available the capacity to build a system that can reduce relapse rates, as I have indicated, care for the public sector patient, and undoubtedly, in a well-managed system, reduce costs overall.

Thank you very much for your time and attention.

Senator WELLSTONE. Thank you, and I apologize for interrupting you. I will actually have some questions that go to the very heart of some of the points you want to expand on, so you will have that opportunity.

Dr. DOCHERTY. Thank you.

[The prepared statement of Dr. Docherty follows:]

PREPARED STATEMENT OF DR. JOHN P. DOCHERTY

Good Morning. I am grateful for the opportunity to address this panel today and I am very appreciative of your attention and concern in taking you time to address the alleviation of the suffering of this nation's mentally ill.

I speak to you today in no official capacity but as a private citizen. My gratitude and appreciation for your time derives from my twenty-three (23) years of work with the mentally ill, as a psychiatrist, and from the fact that my father, whom I deeply loved, suffered from a serious mental illness. I do hope I can bring some useful perspective to this panel based on my experience in psychiatry, which has been in academic, private, state and federal government settings and in work as a clinician, administrator and researcher.

In the United States today, we have properly become concerned with the lack of access to care of millions of Americans. This problem, as terribly serious as it is, pales in comparison with the specific lack of treatment of the mentally ill.

In the United States we, have a national disgrace. Simply put, we do not treat our mentally ill. The National Institute of Mental Health Epidemiological Catchment Area study, the nation's major study of the prevalence of mental illness, found that less than 50% of those patients with schizophrenia received any care within a six (6) month period, less than 1/3 of those with major depression, less than 25% of those with anxiety disorders, less than 15% of those with chemical dependency problems, and less than 10% of those with organic brain syndrome, that is, problems such as dementia. Treatment, in this context, is defined as contact for a mental health problem with any kind of provider, over that six month period of time. ^{that is a single contact.} In Georgia, the Director of Child & Adolescence Services in that State's department of human resources indicated last year that only 18,000 of some 90,000 children who are severely emotionally disturbed received help.

Such neglect of our mentally ill is not tolerable in an advanced society. One of the sources of this grave social problem is an insidiously persistent, primitive prejudice we harbor against the mentally ill. While this attitude may have been understandable in an era when the nature of mental illness, its biology and the psychology and social forces creating it and effecting it were not understood, it makes no sense any longer. Yet it

persists. A Rand Corporation national study of medical practice patterns found, for example, that less than 50% of patients suffering from major depression were likely to be accurately diagnosed on a visit to an internist or general practitioner. Another recent study on 33 patients who were found after angiography to have normal heart vessels, further found that 20 of these patients were suffering from panic disorder symptomatology. This lack of appropriate diagnoses for two major disorders is a reflection of the pervasive lack of understanding of mental illness in our society. It affects all of us, including primary care medical providers.

The cost of this neglect of the mentally ill is extremely high. We add enormous costs to our medical care system by failure to adequately treat the mentally ill. For example, it is estimated that the cost of the misdiagnosis and failure to treat panic disorder, I just mentioned, is responsible for 50,000 unnecessary cardiac catheterizations annually. The under-diagnosis of depression, I cited, is another excellent example. The depressed patient, who appears typically with physical symptoms such as weight loss and loss of appetite, improperly diagnosed, may be subjected to numerous expensive gastrointestinal diagnostic procedures which are completely unnecessary. Furthermore, while all of this is occurring, the functional disability and its cost to work and family life persists and worsens. In addition, extra cost is added to the medical care system from so-called non-compliance, that is, patients not following their physicians' recommendations. For example, patients with hypertension not taking their medication, and patients with cardiac problems not properly following their diet programs. Such compliance problems are often the result of psychiatric disorders. The direct treatment of such disorders can considerably enhance the patient's motivation and capacity to become compliant, especially with a complex medical regimen, and thus decrease other medical care utilization.

The cost of not treating the mentally ill is reflected in numerous other ways. The illnesses do not disappear simply because we choose to ignore them. For example, the L.A. County Jail is now the largest inpatient provider of mental health care in this nation. This trend is present across the country. This is astonishing considering our severe criticism of the Soviet imprisonment of the mentally ill in the not so distant past.

In addition, as a resident of California, during these past two weeks, my own home was closely threatened by the devastating fire storms along the Southern California coast. Twice I had to pack up all of my possessions and move them from my house. My experience was nothing compared to those 500 families who lost their homes and possessions. The single source of the greatest amount of this destruction was an itinerant homeless man building a fire to warm himself. What price is our neglect of the homeless? I do not know, at this point, if this man was mentally ill, but based upon the statistics we do have regarding the percent of mentally ill among the homeless, it is a high probability. The price we have paid for this single piece of neglect is enormous.

The saddest fact of all is that we are, fortunately, at a point in the history of the care of the mentally ill where we have available highly effective treatments to alleviate the terrible suffering and functional disability of these illnesses. Specifically, for the mental disorders of schizophrenia, panic disorder, bipolar disorder, obsessive compulsive disorder and major depressive disorder, our improvement rates vary from 60 to 80%. To get a sense of the magnitude of the effect, it compares with improvement rates of between 40 and 50% for angioplasty and atherectomy for cardiovascular disease.

Furthermore, with appropriate long-term treatment psychiatric practice can reduce relapse rates in schizophrenia from 80% to just over 20%, in bipolar disorder from over 80% to approximately 30%, and in major depressive disorder from 70% to under 20%. Furthermore, we are in the center of a wave of new knowledge that has developed over the last two decades in both basic neuroscience and psychological sciences that has the promise to usher in an entirely new era in the effective treatment of the mentally ill. All of this will be lost without the acceptance of our societal responsibility to fully and completely care for all of our mentally ill.

The problem, as I have presented it to you, might appear vast. We have many people who must get access to the effective care we now possess. In addition, however, to knowing the specifics of individual treatment we also know what the elements of dysfunction in our system are and we know what the characteristics of an adequate system of care must be. Furthermore, it is my own personal belief that there has been a strong

definite shift in the implicit societal mandate of medicine. This shift is from a mandate to develop new specific treatments for individual disorders to the development of a system that would provide better care for more people at less cost. Such a new system in the area of mental health care must insure that the large body of knowledge we possess and the specialized skills of individual providers are woven together so that the particular patient gets proper care, competently delivered, by an appropriately trained clinician, in a timely and cost-conscious manner.

That is, an adequate system of care must be

- o accessible.

The responsibility of the health care system is to adequately educate the public in the recognition and availability of treatments of mental illness, to remove restrictive barriers to care, such as undue financial barriers, and to facilitate entry to diagnostic/referral services structured to determine the most appropriate type and level of care.

- o comprehensive.

making available the range of treatments and alternative treatment settings we know to be effective and necessary,

- o coherent.

that is, precise and integrated, making available to the patient the continuous provision of services constituted specifically to meet the changing needs of the patient.

- o accountable.

The accountability must be twofold. It must be cost controlled and quality driven.

I have personally been extremely pleased with the Administration's clear and vigorous support for the mentally ill.

However, to truly address a problem which is not tolerable in an advanced society, we must take the important step, a morally right step, and the only step that would truly provide for an adequate cost-effective system of care. We must move, as rapidly as possible, to provide parity of coverage for the mentally ill. If we do not many of our problems will persist. Many policies for those with severe chemical dependency problems allow these patients "one shot" at treatment and then no longer provide any benefits. We know that chemical dependency, properly treated, can be controlled. We do also know, however, that like many of our other serious illnesses, it is a relapsing illness. It makes as little sense to have such a "one shot" provision in a policy for health care coverage for chemical dependency as it would for recurrent breast cancer or prostate cancer. Yet, exactly such abusive coverage procedures will persist unless we finally accomplish the enfranchisement of the mentally ill.

Much of the dysfunction and distortions in our contemporary mental health system result from reimbursement structures which make actuarial sense but no clinical sense. For example, in 1989, 62% of conventional insurers had higher co-insurance payments for outpatient and than inpatient services. This type of structure, planned or unplanned, encourages patients to seek inpatient care. Unrealistic lifetime limits set by many companies force patients into public sector care and have overburdened that system. Furthermore, contemporary efforts to manage care, while absolutely fundamental and necessary to the achievement of what I perceive to be our new societal mandate, have been largely cost driven.

This has led to further distortions in our care of the mentally ill, and has worsened our most critical problem -- access to care.

Thus, beside my strong support for President Clinton's proposal I would suggest two critical modifications:

1. There must be a uniform benefit which all plans must provide. For example, all plans must be required to offer case management and non-residential treatment, otherwise, the plan offering this treatment will severely be disadvantaged by adverse selection.

2. From the inception of the plan, the outpatient benefit should be unlimited with 20% co-pay.

I recommend this modification for the following reasons:

- (1) This benefit, linked with the services I just mentioned--case management and intensive non-residential treatment--is essential to instituting a cost-effective system of care which can avoid unnecessary hospitalization and is essential to evolving the treatment capacity and capability to allow for the gradual integration of the public sector patient. Such patients, we know, specifically require these services. More immediately, to help future patients from unnecessarily being shifted to the public sector, we will need these services.
2. While the freedom to exceed 30 visits should exist, if needed, there should not be a trade-off with inpatient benefits. The inpatient benefit represents coverage for an unpredictable and catastrophic state-of-affairs and has to be protected in any reasonable insurance plan.
3. A 50% co-payment is financially discriminatory and will keep our poorer citizens from accessing care thus undermining one of the fundamental goals of health-care reform.
4. The additional expense of this benefit is small even using conservative figures which do not allow for cost-offset due to decreased use of inpatient care.

Other than an anachronistic, primitive fearfulness, there is no basis for continued discrimination against the mentally ill. Such discrimination is as rationally based as similar discrimination would be against those with tuberculosis or diabetes or coronary heart disease. Mental illnesses are mortal, debilitating serious illnesses. Effective treatments exist. We have the capability of delivering those treatments. Such treatment must be available to those of us who have the terrible misfortune of being beset by a mental illness.

Senator WELLSTONE. Dr. Frank.

Mr. FRANK. Good afternoon, Mr. Chairman.

In the interest of full disclosure, I would like to tell you that I served on the mental health working group of the President's task force.

Senator WELLSTONE. Well, that is a plus, because we appreciate the work that has been done.

Mr. FRANK. I am pleased to have an opportunity to comment on the mental health portion of the administration's legislative proposal. In my brief remarks, I would like to comment on four points.

First, I would like to underscore the significance of the long run vision in the President's proposal. Second, I would like to discuss the approach to phasing in various parts of the mental health and substance abuse benefit. Third, I would like to try to define the role of the interim benefit, or the initial benefit, for mental health and substance abuse. And then I would like to point out a few difficulties I have with the final legislative product.

First let me comment on the vision. President Clinton's reform proposal contains a serious attempt at formulating a national mental health and substance abuse policy that is broad in scope, efficient and humane. That vision calls for full integration of mental health and substance abuse care with the medical care system in the United States.

Now, full integration means that from the patient's point of view, there will be no material distinctions between mental health and substance abuse in that coverage for all health care. Each person would subscribe to a plan, and that plan would be responsible for all their mental health and substance abuse coverage, for all stages of their illness. That vision addresses two of the most fundamental problems in mental health coverage today, which are, first, that too much money is spent on costly institutional care, and second, that most families are exposed to the risk of financial ruin from serious mental health and substance abuse problems.

The phase-in that the President proposes is based on the recognition that creating a fully integrated system at a reasonable cost will involve some important changes, and I would like to raise two in particular.

First, there will need to be considerable restructuring of public mental health and substance abuse systems and the manner in which we finance them. And second, we need to develop the capacity in health plans to manage and deliver specialized services for individuals with severe mental health and substance abuse disorders.

For these reasons, it is sensible to carefully phase in the inpatient coverage provisions and coverage of services aimed at treatment of severe disorders such as partial hospital care and rehabilitation services.

However, a more aggressive approach than offered by the administration could be taken to phasing in the ambulatory care coverage. For example, imposing a 30-day limit on top of a 50 percent copayment saves very little money. These services are familiar to plans, and the scientific research on the subject shows very clearly that costs can be controlled without resorting to limits.

The initial benefit. Given that some phase-in of some benefits is sensible, we can consider the initial benefit by how well it advances us toward the President's long run vision and how consistent that benefit is with the general principles of health care reform as articulated by the President.

Given that context, let me make three comments on some features of the plan that I find disturbing. While the key parts that have been proposed are often sensible, there are some features that I think violate both the principles of health reform and are not supported by available research and data.

The three specific features of the proposal that are especially troublesome are, first, alternatives to residential and inpatient mental health and substance abuse care are covered at the discretion of plans—that is, the partial hospitalization and residential care. This provision undermines both the ability to attain the long run vision set out by the President and some basic principles of health reform. Allowing the alternatives to inpatient care to be discretionary provides plans and opportunity to compete on the basis of risk selection—that is, the adverse selection problem that was raised earlier.

Senator WELLSTONE. Do you want to just spell that out for some people? We use this language all the time, but for some it may be unclear.

Mr. FRANK. Yes. Plans that do not offer services specifically targeted to help the severely mentally ill will not attract these people into their plans. Adopting policies to avoid enrollment of individuals with severe mental health and substance abuse disorders encourages wasteful competition for good risks, and not competition based on quality and efficiency. So your success is judged not by how efficient and how good you are, but rather by how good you are at cherry-picking. If plans do not offer these services, they will never learn how to manage them, and therefore the phase-in becomes problematic.

The second difficulty I have is that individuals will be able to trade four psychotherapy visits for each covered inpatient day, enabling people to trade away large parts of the inpatient benefit. This provision is problematic for two reasons. First, it allows people to trade away a lot of their catastrophic coverage for benefits that are not usually associated with the most severe forms of illness. This is especially hard to understand given the absence of evidence suggesting that psychotherapy is a strong substitute for inpatient care.

This provision was motivated by a desire to contain costs. The second problem is that it will save no money and undermines a major purpose of the insurance, which is catastrophic coverage, protecting families against ruinous financial expenses.

This is a provision that does not enhance the financial security of American families.

The third piece is that the legislation calls for excluding out-of-pocket for alternatives to inpatient care from counting toward the overall out-of-pocket max. The only people who use those types of services are people with severe and disabling mental health and substance abuse conditions. These are people with high risk of ruinous expenses. As such, the exclusion of their out-of-pocket costs toward the maximum represents a pure transfer to tax. What you

are doing is transferring money from the most vulnerable and most needy in society to the general population. I believe that this is a sad outcome and defeats the principle of insurance that we are trying to put into place here.

Thank you, Senator.

Senator WELLSTONE. Your last point was on the copays for outpatient.

Mr. FRANK. The copays, particularly for the alternatives to inpatient care not counting toward the out-of-pocket max.

Senator WELLSTONE. Above and beyond individual psychotherapy; other alternatives besides that.

Mr. FRANK. Besides psychotherapy.

Senator WELLSTONE. And your other point, just to be clear, on the four-to-one match, it is not that you consider the psychotherapy unimportant—you consider that to be critically important—it is just that you do not think people should be put in the position of having to give up one of the days of coverage for what could be a real catastrophic expense. Is that what you are simply saying?

Mr. FRANK. That is correct. I believe that it is not responsible policy to allow people to trade away a lot of the catastrophic coverage that they have, and I believe that, second of all, you do not save much by doing this.

Senator WELLSTONE. And the point, just to be clear—I was pushing Dr. Arons on the point that all plans ought to be able to do this if in fact it is feature—what you are really arguing is that you do not really think this ought to be the trade-off.

Mr. FRANK. That is correct.

Senator WELLSTONE. OK. Thank you.

[The prepared statement of Mr. Frank follows:]

PREPARED STATEMENT OF RICHARD G. FRANK

Good morning Mr. Chairman, my name is Richard G. Frank and I am a Professor of Health Economics at the Johns Hopkins University School of Public Health. I served on the Mental Health Working Group of the President's Task Force on Health Reform. I am pleased to have an opportunity to comment on the final product of the Administration's deliberations on Health Care Reform. I will direct my comments to four aspects of the Administration's legislative proposal for including coverage of mental health and substance abuse care under national health care reform. They are: 1) the longrun vision for the mental health system articulated in the plan; 2) the proposed approach to phasing-in of benefits overtime; 3) the role of the structure of the initial benefit for arriving at the longrun vision; and 4) some important shortcomings in the design of the initial benefit.

A. The Longrun Vision for the Mental Health System

President Clinton's health reform proposal represents a serious attempt at formulating a national mental health policy that is broad in scope, efficient and humane. That vision calls for full integration of mental health and substance abuse (MH/SA) care with the medical care system in the United States. Full integration means that from the patient's point of view, there would be no material distinctions between the MH/SA coverage system and that for all health care. Each person would subscribe to a health plan responsible for all MH/SA care that a person would require throughout all stages of illness.

The longrun vision in the President's reform proposal addresses the problem that too many of our resources are devoted to costly institutional care and that most private insurance coverage exposes families to risk of financial ruin from serious illness. Insurance coverage for MH/SA services is typically structured so that it offers the most comprehensive coverage for relatively low level financial risks (20-30 psychotherapy visits and 30 inpatient days), whereas the services needed to treat most severe illnesses (partial hospital care, case management, rehabilitation services, extended acute inpatient treatment) are usually left uncovered. Once an individual or

a family exceeds the limits, they must rely on their own financial resources or rely on an overextended public MH/SA system.

In order to succeed reform of private insurance must remove limits and expand the scope of services covered at a reasonable cost. Creative use of utilization management and provider payment methods (capitation, prospective budgets and performance contracts) open up opportunities for providing deeper coverage.

B. The Phase-In

The purpose of the phase-in of benefits is to guarantee that 1) time is allowed to restructure certain parts of the mental health system, 2) to give health plans an opportunity to learn how to manage and deliver new types of services and 3) to allow cost containment systems to be put into place.

Creating a fully integrated MH/SA system such as that proposed by the President represents a significant challenge for cost containment policy. Creating a benefit structure on par with that of all health care, inclusion of specialized MH/SA services not currently covered and coverage of all Americans at a reasonable costs requires important restructuring of the organization and financing of MH/SA care. Full integration of MH/SA will require considerable restructuring of public MH/SA systems. Developing a capacity in health plans to manage specialized services for individuals with severe MH/SA problems will also require important changes in how these organizations typically deal with MH/SA care. For these reasons it is sensible to carefully phase-in the inpatient coverage provisions and the coverage of services aimed at treatment of severe disorders (partial hospital care, residential care and rehabilitation services).

A more aggressive approach can be taken towards phasing-in of ambulatory care. For example, imposition of a 30 visit limit along with a 50% copayment for psychotherapy saves very little in premium costs. The 30 visit limit is unnecessary. These services are familiar to health plans and the scientific research on the subject supports the ability to control costs without imposing coverage limits.¹

C. The Initial Benefit

Given that some phase-in of some benefits is sensible we can assess the initial benefit according to the degree that it advances the longrun goal and is consistent with the overall principles of the Administration's Health Reform proposal. The longrun goals call for developing capacity in health plans to deliver all MH/SA care. This requires developing the capacity to manage and deliver new services such as partial hospital care, rehabilitation services and residential care. These services have traditionally been delivered by the public sector. Thus, creating an intermediate benefit would give health plans responsibility for developing the ability to deliver these services while not imposing all responsibility for which they may not be technically capable of meeting during the initial phases of health reform. Similarly, expanding inpatient coverage represents a move to provision of catastrophic coverage for MH/SA problems. However, since much of the responsibility for treatment of catastrophic MH/SA problems has fallen on the states an intermediate step allowing states to smoothly restructure their financial and organizational arrangements is sensible.

D. Shortcomings of the Proposed Initial Benefit

While key pieces of what has been proposed are sensible there are some critical features of the legislation that violate the principles upon which Health Reform is based and are not supported by available data and research. I believe that much of the reason for these provisions comes from concerns over the costs of the benefits package. While there are certainly legitimate concerns in this area, I believe that they have been overstated and that the responses to those concerns represent an incomplete understanding of cost and utilization data for MH/SA. Specifically, the administration estimates of MH/SA costs are based on very limited data on the public MH/SA system and Medicaid which represents a large share of all MH/SA spending. This incomplete assessment is most clearly seen in the types of assumptions that the administration has made on the costs of covering: 1) those currently uninsured and 2) individuals who are currently uninsured and suffering from serious MH/SA problems.

There are three features that are especially troublesome that I will comment upon.

1) Alternatives to residential and inpatient MH/SA care are at the discretion of the plan. This provision undermines both the longrun vision of a fully integrated

¹Manning W.G., et al, *Effects of Mental Health Insurance: Evidence from the Health Insurance Experience*, RAND Report R-3815-NIMH/HCFA 1989, The RAND Corp.

system and the basic principles of health reform. Allowing the Alternatives to inpatient care to be discretionary provides plans with a means of competing on the bases of risk selection. That is, plans that do not offer the alternatives which are targeted at individuals at risk of severe MH/SA problems will avoid enrolling such individuals in their plans. Adopting policies to avoid enrollment of severely ill individuals will potentially yield large profits for health plans under the health reform proposal. These profits would not stem from efficient economic performance, but rather from successful risk selection. In addition, if plans do not offer the service they will never develop the necessary expertise to manage and deliver the services called for by the fully integrated system.

2) Individuals will be able to trade 4 psychotherapy visits for each covered inpatient day in the plan enabling people to trade away their entire inpatient benefit. This provision is problematic for two reasons. First, if a basic principle of insurance in general and health reform in particular is to offer families catastrophic protection against the risk of financial ruin due to serious illness, then allowing people to trade away all inpatient coverage in order to obtain extended psychotherapy coverage violates that principle. Second, this provision will tend to raise rather than lower costs. This is because relatively few people use inpatient care relative to psychotherapy. Thus the pool of people likely to trade away inpatient days is relatively large. Moreover, there is no strong research evidence that suggests that psychotherapy represents an important "substitute" for inpatient care. The drafters of this provision appear to have lost sight of the fact that an insurance benefit is not intended to provide a pot of money to use but is instead intended to offer financial protection against the consequences of illness. In general, health insurance should be something you do not want to use.

3) The legislation calls for not counting out of pocket costs spent on alternatives to inpatient care to count towards the maximum out of pocket liability specified in the plan. This provision violates the catastrophic protection goal. The alternatives to inpatient care are only used by individuals with severe MH/SA problems. These individuals will with a high degree of certainty incur ruinous levels of expense. Exempting their out of pocket costs on the alternatives from the maximum liability rule represents a "pure transfer" from the one of the sickest segments of the population to the rest of society. This is hardly in keeping with the humane and efficient vision that the President has set out for the treatment MH/SA problems in America.

Senator WELLSTONE. Dr. Crowell.

Ms. CROWELL. Good afternoon. May I add my words of appreciation for your leadership and my strong appreciation for the inclusion of mental health in the Health Security Act and for the leadership that that represents for persons with severe mental illness who have been trying hard to get recognized on a parity basis with the rest of health care. We think this is an enormously important step forward, and we support the principles.

From the public sector perspective of a person who has been responsible for the delivery of care to essentially the uninsured and the Medicaid/Medicare-eligible population for some time, I share many of the concerns expressed by my colleagues, and I will put these in the context of our experience in Los Angeles County in California and will not repeat the points that they have made that I think are extremely important.

My bottom line would be that I concur that case management and the intensive noninpatient services must be mandatory. To the extent that they are not, we will see cost-shifting to the public sector. That is really the bottom line of my testimony.

We have considerable fear that this traditional approach will actually drain funds away from the seriously mentally ill to provide therapy and other services to an enlarged population of beneficiaries who can indeed and should get those services. But it should not be done by draining away from an already inadequately funded public sector responsibility.

There is also fear that blending the substance abuse and mental illness language as it is in the Act will further exacerbate that

tendency to drain funds away from the seriously mentally ill. We do not have the capacity to begin to find the treatment for persons with substance abuse in Los Angeles County in the public sector that is needed. We cannot see that they are going to be improved by this structure of the approach taken.

I would like to make the point that we already pay a great deal for the failures of the current mix of insurance benefits that very often exclude people when they most need care. We pay for it directly in emergency rooms, jails, courts, group homes, other institutional responses, or we pay indirectly in preventable violence and the blight of homelessness that has already been referred to.

The parents of persons with serious mental illness have two major fears, one, that their adult child will threaten them and that law enforcement will respond and injure or kill them or their child; or second, that they will be lost to the streets. Both situations result in the failure from adverse selection and all the other negatives of our current system.

I would point out to you the importance of law enforcement. We have 1,250 persons brought each month to our Los Angeles County public psychiatric emergency rooms for psychiatric care. Nearly 10,000 people were treated in our jail programs for the mentally ill. That cost us \$5 million for the mental health component, but the jail housing costs are an additional \$36 million, so it was a total of \$46 million for services to mentally ill persons in certainly the most restrictive and least therapeutic of environments.

Senator WELLSTONE. And most costly.

Ms. CROWELL. Well, it is not as costly as our acute psychiatric hospitals, but they would not have had to stay there as long. And we did not even count the law enforcement officers' costs or the court costs that go into all of this.

Substance abuse problems contribute significantly to those costs that I have just referred to. Seventy-five to eighty percent of the persons seen in our psychiatric emergency rooms have a substance use problem. That will result in bizarre behavior which brings them to us. We find that one-third have only a substance abuse problem; the others may have a dual mental illness and substance abuse. One of the features of the plan as put forward is to pay for the medical detoxification for those individuals, that will be helpful, because that is essentially what we are doing in our psychiatric emergency rooms. Those costs get counted as mental health costs rather than substance abuse costs.

There is a great deal of concern that providing care to the public sector will make the mental health benefit too expensive. I would like to speak to that. Our total costs in Los Angeles County, the public sector that we can identify, are about \$44 a year per person in the population. That is \$4 per month or less. That is not a large amount of the total benefit package. Admittedly, our coverage now is not what it should be. We do estimate that we are able to serve perhaps half of the ones that we should be serving now. But it is very difficult for us at the practical end to estimate how much of the benefit as designed will actually substitute for those costs. I think that is a very important feature that does need to be worked on, and we probably can work with some of the actuaries and economists to try to get a better database for that.

But we do have evidence of efforts that when mental health benefits are designed with the flexibility that is necessary so that you can provide a variety of services, then you can indeed make significant savings even in the public sector.

For instance, for children and youth, we have had a pilot program in California for several years that demonstrated savings in three counties in group home placements alone of \$35 million. Translated to the entire State, that would have been a savings of \$98 million a year out of a \$225 million expenditure by investing in mental health services up front. That is the kind of benefit that we need to have designed into this program.

For adults, we have been working with integrated service agency programs for seriously mentally ill persons using capitated funding approach of about \$17,000 a year for persons who have been previously costing significantly more. It is \$100,000 a year to serve somebody in a State hospital; it is up to \$60,000 in other kinds of intensive, 24-hour care.

Integrated service agencies are designed to meet the unique needs of adults with serious mental illness and revolve around a personally involved, direct case management service team—not a remote phone-in type of case management so common to HMOs or other managed care providers. The team is available 24 hours for emergency support, hospitalization, if necessary. I must point out that we do not eliminate hospitalization for these individuals; we simply are able to reduce the overall expenditure for those services. It relies on an intimate knowledge of the person over time to engage them in appropriate treatment and rehabilitation.

We have shifted over 500 of our most costly patients in Los Angeles County to this approach, those who averaged over \$30,000 a year in the past, to a capitated approach at about \$17,000 to \$20,000 annually total public cost.

We have demonstrated that appropriate field interventions with law enforcement and mental health can divert people from jails and from emergency rooms. These are not traditional health organization interventions. That flexibility must be built into the package.

We are very interested in the efforts to streamline administration and financing. Medicare and Medicaid are a good place to begin with their redundant regulations that do indeed cost us money that could instead be spent on services.

In summary, we are very supportive of the inclusion of mental health in reform, and we believe that properly developed, it can be cost-effective and will not break the bank.

Thank you.

[The prepared statement of Ms. Crowell follows:]

PREPARED STATEMENT OF ARETA CROWELL

Good Morning. My name is Dr. Areta Crowell. I am the Director of the Los Angeles County Department of Mental Health, one of the largest local public mental health authorities in the nation, serving a highly diverse population of 9.1 million residents spread over a 4,000 square mile area.¹

¹ The Department of Mental Health serves persons with severe and persistent mental illnesses through a network of County-operated and Contracted programs. The network includes two (2) State Hospitals, 28 directly operated adult programs at 23 sites; eight (8) co-located programs

The County administers Public Mental Health System cared for 69,933 (70,000) severely mentally ill persons in 1992-93 at a cost of \$357 million. Another 50,000 persons received services under the Fee-For-Service (FFS) Medi-Cal system, at a cost of \$58.7 million. Together, the public mental health expenditures for these 112,000 unique clients (children, adults and older adults), amounted to over \$400 million. Of this amount, the Federal programs covered \$98 million or 24%. This is not all of the Federal investment in mental health services in this County; an unknown amount of Medicare-funded services are provided outside State or local government management.

Inclusion of adequate mental health service benefits in Health Care Reform is vital to people with serious mental illnesses. Los Angeles County and our entire mental health constituency applauds that this fundamental recognition has been included in the Health Security Act: This inclusion represents enormous progress in bringing a very stigmatized group of people into the mainstream of health care. Health Reform must recognize that mental illness is more prevalent than many other chronic illnesses and creates a severe burden for families and the community. However, we are concerned that the benefit as currently structured does not incorporate all that we now know about good design: Knowledge gained through painful experience and sound research. We do need a benefit that will provide appropriate treatment and rehabilitation services in a system of care which provides an identifiable single point of accountability for each consumer and family with flexibility to meet their varying needs.

Such a single system approach can leverage health dollars in other essential human service areas to assure that optimal consumer outcomes are achieved.

Successful National Health Reform must make it possible to:

- Foster continuity of care for the seriously mentally ill;
- Fund treatment and rehabilitation;
- Prevent cost-shifting out of health care into other areas of local government responsibility such as emergency care and law enforcement.

The mental health benefit must not be structured and funded in such a way that it will erode already inadequate services and current Medicaid benefits for persons with serious mental illness. There is considerable fear that the traditionally based benefits now proposed in the Health Security Act will drain funds away from the seriously mentally ill, leaving more community problems than before. There is also fear that the substance abuse benefit not be so co-mingled with the mental health services that more competition is created between two underfunded systems. Certainly, co-occurring problems are a major concern and their prevalence must be recognized if effective service systems are going to be available. Serious mental illnesses present a complex challenge for Health Reform, but that does not mean they should be ignored or put on the back burner. If Health Reform does not provide appropriate treatment and rehabilitation for the mentally ill, then our society will pay, either directly—in emergency rooms, jails, courts, group homes or other expensive institutional responses—or we will pay indirectly in preventable violence and the blight of homelessness.

Traditional mental health insurance benefit design does not meet that test. Unfortunately, all too often, traditional public service system design also fails that test. But system design failures should no longer be tolerated and certainly have no place in National Health Reform.

Unfortunately, we do not need to look far for evidence of the failure of the current mix of traditional insurance benefits, Medicaid, Medicare and State and local funding—a mix which has often been costly for the insured but does not provide treatment for all of the persons with severe mental disabilities.

In today's delivery system, many people do not get care until they deteriorate to the point where the community calls for intervention by law enforcement. Each month the police bring over 1,250 persons into Los Angeles County emergency rooms for psychiatric care. Because of fragmented responsibility and underfunding, these hospital emergency rooms and law enforcement have become the front line of the public treatment system. Los Angeles has the unfortunate notoriety of having more mentally ill persons in jails than in hospitals at any time. Nearly 10,000 persons were treated in our jail programs for the mentally ill, at a cost of over \$5 million in 1992-93. The lack of resources, lack of benefit coverage and fragmented sys-

with Department of Public Social Service (DPSS) office; one (1) Countywide Specialized Case Management and six (6) Integrated Services programs; Forensic programs in County jails; and interagency agreements with the County Department of Health Services at four (4) County Hospitals for inpatient and outpatient services. There are 18 programs for children and youth. The Department administers over 400 mental health contracts with 100 private community agencies.

tems have shifted costs to the public sector and to the "back end", high cost part of the system. These costs have been borne mostly by the State and local taxpayers, not by the Federal government, especially in California which ranks 51st among the States in Medicaid reimbursement!

Lack of adequate substance abuse treatment also contributes significantly to the costs of the public psychiatric system. About 75-80% of persons seen in psychiatric emergency rooms in Los Angeles have a substance abuse problem. Bizarre behavior brings them to us, but we find that $\frac{1}{3}$ have only a substance abuse problem, the others have a dual diagnosis of mental illness and substance abuse. We estimate those with only a substance abuse problem cost the psychiatric emergency rooms about \$3 million. Law enforcement costs are an additional local burden of these untreated illnesses.

But not all is gloomy regarding the cost of treatment for the mentally ill. A well designed, integrated system has been shown to reduce reliance on restrictive levels of care, both for adults and for children and adolescents with severe emotional disorders. California has demonstrated savings for children and youth in 9 small pilot counties of over \$35 million in 3 years on total AFDC Foster Care costs through early mental health treatment, service coordination and integration of resources. Similarly, based on many demonstration projects around the country, Integrated Service Agency programs in California are serving seriously mentally ill adults with capitated funding of \$17,000 per person/per year contrasted with nearly \$100,000 per person/per year in State Hospitals or \$60,000 per year in specialty skilled nursing programs.

In Los Angeles County, we have shifted over 500 of our most costly clients, who averaged \$30,000 in public cost per year to Integrated Services Agencies at a cost of \$17,000 to \$20,000 annually. We have also demonstrated that appropriate field interventions can reduce emergency room and jail episodes for serious mentally ill persons, thus reducing total public expenditures. But, these are not traditional health organization interventions.

Another fundamental principle of Health Reform has been to simplify and streamline the system of delivery and financing. We applaud that objective. The present system of funding mental health services certainly can benefit from such efforts. Medicaid and Medicare programs carry unnecessarily duplicative billing, regulations, policies and procedures which certainly reduces the funds available for treatment services. California has already expressed its strong interest in working with HCFA and the CMHS to demonstrate a single system of eligibility, service planning and funding.

The potential benefits of National Health Reform will be negated by cost shifting unless coverage for mental illness is designed to provide the comprehensive care which prevents exacerbation of symptoms and increased local costs. Unfortunately, it appears that traditional design has been the basis for disagreements over the cost of the optimum mental health benefit which was originally proposed by the Mental Health Task Force. A benefit focused on hospital bed days and outpatient visits accompanied by a 50% copayment is retrogressive. Beyond that, even with a subsidy for those in poverty, copayments will not cover costs; therefore, we predict that patients—and costs—will shift to the public sector or simply leave more people untreated.

In conclusion, public sector mental health administrators strongly support National Health Care Reform with the inclusion of a mental health benefit which will be meaningful for persons with severe and persistent mental illnesses, prevent cost shifting to state and local government, and achieve a single system of care for all. Those who suffer from debilitating mental illness and its effects deserve the same chance to get well as persons with heart, cancer or other illnesses. Thank you.

Dr. Wellstone. Thank you very much.

Dr. McArdle, if you were to remove the limits on the outpatient psychotherapy services and lower what the patient would have to pay in terms of coinsurance, what in your judgment would be the impact on per capita cost and the overall cost?

Mr. McARDLE. I will ask Dale Yamamoto, our actuary, to give you the real nuts and bolts on that.

Dale?

Mr. YAMAMOTO. In the graph that we have given you, we are showing, for example, in the high cost-sharing plan, the cost would

go from \$225 per person to \$265. So that is a cost increase of approximately 18 percent just on the mental health portion.

I do not really have the numbers prepared, but the cost on the overall benefit package would probably be in the neighborhood of one to 2 percent.

Senator WELLSTONE. An increase of one to 2 percent in the overall package?

Mr. YAMAMOTO. Yes, for the overall package.

Mr. MCARDLE. The price he has given you there is for the unmanaged plan.

Senator WELLSTONE. That is the unmanaged plan. This is not the sort of—what I hear you all emphasizing—the importance of the case management, your definition of managed care through case management; that is not even building in some real changes in the delivery. So give me the first figure again—an increase of one to 2 percent—what was the figure you thought?

Mr. YAMAMOTO. That was approximately 18 percent, going from \$225 per person to \$265 under the high cost-sharing plan. If we focus on the—

Senator WELLSTONE. This is when you remove the limits?

Mr. YAMAMOTO. Yes, removing the limits.

Senator WELLSTONE. Why are your projections—this is one of the points of contention, and this is one of the questions I think we really have to zero in on—the administration seems to be saying that they need the 50 percent copay, and they need to not count those expenses toward the cap because they are very worried about the overutilization that would take place and, if you will, the extreme cost of it.

The figures you have just presented are very different. Why are your figures so different?

Mr. YAMAMOTO. Well, our data is primarily based on an insured group, an employee group, probably much more control over potential adverse mental health behavior than the population in general. We have to take into consideration that these people are employed for the most part.

The data does include costs for dependents.

Senator WELLSTONE. The more important figure, though, as I see it, is the 80 percent unlimited you have got down here, is altogether \$200; is that correct?

Mr. MCARDLE. That would be in the low cost-sharing model, yes.

Senator WELLSTONE. And the key difference there is that you have changed the delivery of it; right? This is with real intensive case management; is that the key difference?

Mr. MCARDLE. That is correct.

Mr. YAMAMOTO. Yes.

Senator WELLSTONE. It strikes me that one of the major differences here is that you build into your assumptions as you look at the actuarial costs that if you in fact manage care through really effective case management without having the onerous copays and all the rest, you really would not have the problem of overutilization.

In other words, you think you could really have comprehensive and flexible care and that it would be clearly affordable for the Na-

tion if you do it through this intensive case management approach; is that correct?

Mr. MCARDLE. Yes, we would agree with that.

Jack, do you want to add something here?

Senator WELLSTONE. I am just trying to get at what the differences are in these projections.

Dr. MAHONEY. To clarify just a bit, it is a combination of both case management and adequate assessments of cases on the front end, so that when an individual presents to the system, his needs are clarified, the appropriate treatment resources defined, and then the case is managed throughout all phases of treatment. This is what we see in an employee database, and this is the basis for our assumptions and those results.

Senator WELLSTONE. In addition to assumptions, are you using newer data than the administration?

Mr. YAMAMOTO. Our data base is based on approximately 8 million lives and is primarily from 1991 and 1992.

Senator WELLSTONE. So you are.

Mr. YAMAMOTO. I am not aware of the data the administration is using.

Mr. MCARDLE. The limited exposure that I have had to what the administration has been using is that they have been using large, public sector datasets, which they have then updated for inflation.

Senator WELLSTONE. Let me ask Dr. Frank; he may be able to shed some light on this. I was just asking as to whether or not the data was newer data.

Mr. FRANK. I lost track of the administration's estimates at about the 4,000th revision. But at that time, the baseline was being set by the national health accounts, and then assumptions were being made about that.

Mr. MCARDLE. I think what is particularly true about our data is not only the time period for the claims experience, but what is particularly new about it is the application of these managed techniques, and that is really what—

Senator WELLSTONE. I want to ask you about that. I want to ask Dr. Frank first of all, what is the national health account? What is it?

Mr. FRANK. They were originally done in 1985 by Dr. Dorothy Rice, and then they were projected forward to 1990, using the general national health accounts growth factors.

Senator WELLSTONE. I thank you, because Dr. Arons in his testimony I thought was very forthcoming in that if we have some newer data, if we have some different assumptions that could be injected into this process in terms of trying to make sure we come out with the most credible, most effective, most workable policy, they are open, and it seems to me that that is part of what you do bring to this hearing, and I am hoping we will be able to work with the administration on the basis of, Dr. McArdle, some of what you have to offer.

Mr. MCARDLE. I think we can bring that; it is going to require your leadership, however, in getting the parties together to go through these nuts and bolts, because as you said, it is very technical, and it is not a lot of fun for people sometimes.

Senator WELLSTONE. What is a good managed mental health care plan? It seems to me that we have been talking about that, but I would just like to get your summary of it.

Everybody talks about "managed care," and people mean so many different things.

Dr. MAHONEY. That is one of the unfortunate aspects, that there are many definitions. To us, a good managed mental health program has a few cardinal aspects. The first is easy access so that an individual can access the system as early as possible in the progression of their illness. We know that these are chronic, progressive conditions, so that if somebody can get in earlier, the changes of it being resolved or treated on a lower level are very good.

The second aspect is a wide array of treatment resources. This includes not only setting, outpatients and inpatients, but also the type of therapist or the type of provider who is involved. There needs to be a great deal of flexibility in matching up the treatment to the individual person's needs.

The third is that too often we think the treatment ends once the individual leaves the facility or has his last outpatient visit. In reality, again, we are dealing with chronic relapsing conditions, so we need ongoing care for the individual.

Overlapping all of this, if you will, is an emphasis on what the individual needs, and this in most employer settings translates to some form of management where the individual has access to a person who knows his needs, can assess changes in condition, and can make the appropriate match.

Senator WELLSTONE. I thank you.

I have a couple more quick questions, Dr. McArdle. The Health Security Act now includes a one-day deductible for inpatient care. I want to zero in on that for a moment.

Mr. MCARDLE. That is correct.

Senator WELLSTONE. Can you estimate what the cost would be to the plan if the one-day deductible were eliminated?

Mr. MCARDLE. Yes, we can. As a practical matter, that is a kind of unusual approach in most of the employer plans that we deal with. Typically, there would not be that large and up-front deductible because it would discourage access. Dale has actually been working on some costs effects of that.

Mr. YAMAMOTO. We see a lot of variation between potential inpatient visits and the mental health arena. Just to give you a sense of the magnitude of some of the numbers, on average, we would expect about six admissions per 1,000 covered employees, and at the rate of \$750 per day, that comes down to about \$5 per year per covered person.

Senator WELLSTONE. That is an important figure given the trade-off.

Mr. YAMAMOTO. It is real insurance. It is spreading of the benefit to everybody.

Senator WELLSTONE. I think you just answered this question—have any of your plans found it necessary to use this inpatient deductible to control costs?

Dr. MAHONEY. I am not aware of any of our employers who currently have that design.

Senator WELLSTONE. Last question. How quickly do you think new managed care systems could come up to speed—I believe one of you spoke to this, but I think it is worth emphasizing again—to meet the demand? If the benefit package pointed in the direction of what we would agree is good managed care, how quickly do you think we could get that up to speed?

Dr. MAHONEY. I hesitate to put years to this, but I think it is quite rapid, because again we are looking at taking technology and knowledge which currently exists and disseminating that more into the treatment community. So it is more an emphasis on how much push we give in getting that out there. We are not looking at a long progression here.

Mr. MCARDLE. I think the key, too, is what you mentioned, which is putting in the incentives so that they are clear and strong. If that were the case between now and 1998, you would see a lot of activity in that direction. I think the problem now is that the incentives are ambiguous.

Senator WELLSTONE. I have to say this deductible is something that I really want to zero in on, especially given some of the data that you have presented.

Dr. Docherty, let me ask you this. Why do you feel that we need an unlimited outpatient psychotherapy benefit in the basic benefit package? That is your position, is it not?

Dr. DOCHERTY. That is my position. I feel we need that because it is fundamental to accomplishing the shift in the system of care that I perceive this health care reform initiative to be about. We would like to be able to treat patients in the least restrictive setting so that their lives are disrupted as little as possible.

On the basis of the minimal extra cost, which is a conservative estimate, there is very little reason not to have this unlimited benefit in place.

We need a system that allows us to take care of people when they have needs. We know that we can reduce relapse rates, as I mentioned earlier, enormously if we can have the continuous coverage of the patient in his natural setting. To drop a rate from 80 percent to 20 percent, which we can do with schizophrenia with effective treatment like this, over a 2-year period of time is really a remarkable clinical accomplishment, and a tremendous cost-saver which is not factored into these estimates.

That cannot be accomplished if we have to worry about 30 visits and when you are going to use it and when you are not going to use it. We really need that unlimited flexibility.

Second, we know that outpatient care, by and large, in an unlimited system is predictable. It is not as though there are going to be vast increases in this. So that on the basis of data available, we know that that myth is really untrue.

The transition to public sector care into an integrated system, which I think is extremely important for our country, can only be accomplished if we have this kind of flexibility available for the severe and chronically mentally ill. If we do not, we will never build the kinds of treatment capabilities and capacities that will allow those patients to be maintained in an organized system.

Senator WELLSTONE. Let me zero in on this point that you have just made. This is something that I am trying to understand better,

not because any of this is new to me—because of my experience with my own brother, I know a fair amount about the struggle of mental illness—but at a policy point, when we look at the administration's proposal and how it would affect the treatment of the seriously mentally ill, we have the inpatient over here, and we know what is covered and what is not; and then we have also talked about outpatient psychotherapy, which some people would argue has no connection to the seriously mentally ill, but I do not think you make that argument; I think you make the argument quite clearly that indeed it does—correct?

Dr. DOCHERTY. Yes.

Senator WELLSTONE. OK. I guess there is a debate about that, but I think you are right. But regardless of where you come down on that debate, the question is where is the infrastructure, the community-based infrastructure, for people who are seriously mentally ill for whom 60 days, or 90 days, for that matter, a year is not going to do the job—right—

Dr. DOCHERTY. Yes.

Senator Wellstone [continuing]. And for whom, if you had the care, we would be much better off as a country not only in terms of more humane and more just and more fair, but also dollar-wise. That strikes me as being a real missing piece.

Dr. DOCHERTY. That is a missing piece. The outpatient benefit is just a part of it. The other piece that both Dr. Crowell and I mentioned earlier regarding the availability for case management and intensive outpatient services, and that Dr. Frank mentioned regarding the necessity for treatment alternatives in all plans, are the other critical pieces. You cannot have a system that cares for the severely mentally ill without those in place, and I could give numerous examples of this.

These are not people who come easily to a scheduled session that you set up a week before. Their condition will vary on a daily basis, in ways that prevent them from getting care.

For example, we have a continuous treatment team in this system that I am overseeing, and those people who carry beepers, are available 24 hours a day, will have to go to the person's house maybe for several days and talk to them through the door and pass little notes, and then the first contact they may get again is the person calling them saying, "I need some milk." This is a real example.

We have another patient who is very paranoid, a kind of scary guy, but doing very well, and actually very harmless, who had trouble getting an apartment. Through the kinds of interventions that the treatment teams of this case management allows, we were able to go to the landlord and talk with him, saying if we could get reassurances from the local police chief, whom these individuals also got to know, would you let him have the apartment—which worked out. That man is stable now. He had been hospitalized almost chronically over the preceding 10 years, and has not been hospitalized for the succeeding year and a half. We cannot do that without this flexibility.

Senator WELLSTONE. And it strikes me—and I see Dr. Crowell nodding, and I want to get your views as well because you live with this in your professional work—but it strikes me that it is not only

the question of the community-based infrastructure, but it is also State institutional care as well, because once not covered, that is where people are going to be headed.

Dr. DOCHERTY. Yes.

Senator WELLSTONE. Dr. Crowell, I wonder if you might also respond to this question that I have raised as to whether or not this is a missing piece?

Ms. CROWELL. What Dr. Docherty has described is exactly the State of the art in terms of what we know works and how it works for persons with long-term severe mental illnesses. And in fact when I talked about our integrated service agency, that is what we are doing, and that is how we are able to bring the average cost per person down from \$100,000 to \$17,000 to \$20,000, is by doing exactly that kind of thing.

There are, of course, some persons who, even with that kind of support, cannot make it in the community. You do have to have a lot of other alternatives as well, and those, of course, are not at all included in the package as described because they are permanent residential for much longer periods of time than covered in this benefit, even at the 2001 as described.

Senator WELLSTONE. Is this what you meant when you said case management—you said something like the bottom line, or if I had one essential message today, it would be that case management, quote, has to be mandatory, or you are just going to see a massive shift to public sector?

Ms. CROWELL. Case management and, I would say, the intensive, nonresidential, noninpatient, but that whole range is how you manage, how you provide all those services; that is absolutely the bottom line, or you will see massive cost-shifting. We already see it. We see lots of people who have HMO coverage, but are not being provided appropriate services, who therefore end up in the public sector.

Senator WELLSTONE. Do you think that the 50 percent copay on outpatient is going to essentially—I do not know what the right word is—force people or send people into the public sector part?

Ms. CROWELL. Absolutely. I am again talking about people who are poor, who often are not educated, and they are not going to see the need, and they are certainly not going to pay for it out-of-pocket and are not going to pay for it out-of-pocket, so they will end up again in the public sector one way or another.

Senator WELLSTONE. Thank you very much, Dr. Crowell, and if you want to elaborate further, please do. We asked you to come because you have such expertise in this area on the basis of the work that you do.

Ms. CROWELL. I think I might like to add that it is important to understand that the public-private, Government-managed network that exists is an essential community provider ingredient that cannot be ignored and must be, I think, transitioned carefully into whatever future we see ahead of us.

There is much more skill in that sector now for dealing with the seriously mentally ill than you will find in most of the managed care provisions. We are talking about people who start off with many more disadvantages than those who are employed and whose

coverage comes from employment, and I think that is a fundamental difference that cannot be ignored.

Senator WELLSTONE. This is my last question. Ellen Schaffer just handed me a note, pointing out that the plan does cover some of the community-based services, and this is the 120-day nonresidential. So I guess the question is is it going to take some time to build up the infrastructure to provide those services. That would be a question for any of you.

Ms. CROWELL. Well, some of that infrastructure exists in the public sector and the public-private partnerships that have been developed. They need to be tied into this package very carefully, and we recommend that they be considered essential community providers rather than being left out.

Dr. DOCHERTY. I think that capacity could come up very quickly if the funding were stable, and it would be utilized. For example, in Connecticut, which has had a long history of a partial hospital benefit, in the facility I am most familiar with there, there is an 8-to-1 utilization of partial to inpatient care. That is not characteristic of other States where this benefit is not regularly available.

Senator WELLSTONE. Dr. Frank, I want to conclude with you on the numbers. There is a lot of uncertainty about the question of utilization by the seriously mentally ill and how it would change under national health care. What do you expect to see happen, and I would like to get some sense of how you arrive at your number and whether it is lower or higher than HCFA's—I think I know the answer to that—and how you explain the difference between your lower estimate and HCFA's estimate.

Mr. FRANK. I think you are correct. I believe there is a lot of uncertainty generally, and my reading of the research literature, which is where my numbers come from, the epidemiological catchment area survey that Dr. Docherty referred to addressed this issue explicitly. It looked at utilization rates for people who met criteria for serious mental illness who were insured and those who were not insured, and the difference in utilization for these people who met these diagnostic criteria was somewhere in the 17 to 20 percent range. So I think that provides you at least a reasonable point of departure in making projections.

Senator WELLSTONE. I am going to include in the record of today's hearing 35 articles in cost-effectiveness dealing with mental health and substance abuse.

[Editor's note—The committee has received numerous letters and articles on Mental Health and Substance Abuse. Because of the volume and cost, it is feasible for the committee to print only the official hearing and testimony presented at that time. However, all the letters and articles are retained in the committee files.]

Senator WELLSTONE. The administration has put a lot of time into their work, and I know you were a part of that, and we all appreciate this hearing today and the points we are trying to get clear. And I think it is within a cooperative framework, not adversarial. We care fiercely about these issues, and we want it to be the best possible policy. That is the intention of this hearing.

So given that background, what would you see as the weak points in some of the numbers that we are getting from the administration and some of the estimates they are making?

Mr. FRANK. I think Dr. McArdle said something very important earlier, which is that actuaries and many people who make projections in this area work primarily with insurance data and dataset from large insured populations. And I think when you start delving into the mental health care and talking about a very comprehensive benefit such as the one being discussed here, you have to understand a lot about the data in the public sector. I think it is probably there that you might find some difficulties, because what an uninsured mentally ill person has access to and can get is very different from that of the general uninsured population.

So I think that when you start to consider that, and you consider it in the context of the type of benefit being proposed by the administration, you really need to get very close to those data, and I am not sure of the degree to which that has happened.

Senator WELLSTONE. Did you give me a figure as to what you thought it would cost to add the uninsured to the plan?

Mr. FRANK. Again, I think what the research literature tends to support is that the differences in prevalence between the general uninsured population—not those who are seriously mentally ill, but the general uninsured population overall—there is about a 20 to 23 percent difference in rates of any kind of problems compared to the overall population.

Senator WELLSTONE. My final point is that there was something in your written testimony that I thought was interesting. You said you thought the phase-in by 2001 was a good idea. If it is a good benefit, then why 2001 as opposed to 1998?

Mr. FRANK. What I said was I thought having some phase-in was a sensible approach. I am not sure there is anything magical about the year 2001.

I would like to emphasize a point that has not been touched on, which is the public financing of the benefit. We are a country that has relied on the States and localities to fund our public mental health systems. We are also a nation that has permitted huge variation in how we do that. The State of New York spends close to \$120 per capita on mental health care in a public system, and that is across the whole State. The State of Iowa spends closer to \$17.

Putting into place a uniform benefit across those localities therefore offers us a lot of complexity in how we try to finance it in a fair manner, and I think that careful thought so that we restructure our public systems and finance them sensibly requires at least some phase-in, but I do not believe there is anything magical about 2001.

Senator WELLSTONE. Thank you.

Dr. Crowell.

Ms. CROWELL. If I might add on to that, I think that is an extremely important point. California, as everyone knows, is going through an enormous economic restructuring, and the moneys available for public mental health have been decreased significantly from the State and local government. They will continue to decrease in the years ahead, and if there is no bridging structure, there will be no incentive to local government to maintain the

structures that are there now; they will erode and disappear, and we will see things far worse than today, unless the benefit is going to be there, and it is very clear how we are going to structure from here to there.

Senator WELLSTONE. I think that that point is a critical one. I do not think I would raise this as a question—unless you all have very different answers—but I take it that built into your definition of good managed care would be a choice of caregiver, at least to the extent that you can do that. Is there any disagreement with that?

[No response.]

Senator WELLSTONE. OK. I do want to note for the record that Dr. Docherty is going to be submitting several studies that we want to include.

I also want to say to each of you that I want to keep the record open for 2 weeks so that other Senators—a good number of people are not yet back today—can submit questions to you in writing.

Also—I have not had a chance to say this yet to Mrs. Carter; I do not want to call her until I know that she is feeling better and can receive a call—but I want to invite her to come and testify, and I think that is going to be very important, but I think that what you all have done today is extremely important, extremely important. I think you have focused our attention on some of the most basic, critical questions, critical points of contention; you have zeroed in on some of the numbers and some of the assumptions. I think we just need more clarity on all of this, and I think you have really contributed to that, so I would like to thank you very much for your time and for your advice and for your wisdom.

Thank you very much.

[Additional material follows:]

ADDITIONAL MATERIAL

DISCLAIMER

The following is a report of the National Advisory Mental Health Council, an independent body. The recommendations contained in this report do not necessarily reflect the views of the National Institute of Mental Health (NIMH), the National Institutes of Health (NIH), the Public Health Service (PHS), or the the Department of Health and Human Services (DHHS).

Health Care Reform For Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council

INTRODUCTION

In its report to accompany the Fiscal Year 1993 Appropriations Bill for the Department of Health and Human Services, the Senate Committee on Appropriations stated:

The Committee appreciates the report of the National Advisory Mental Health Council entitled, "Mental Illness in America: A Series of Public Hearings," which includes a special recommendation on the need to provide coverage for severely mentally ill Americans under national health care reform. The Committee requests that the Council prepare a report on the cost of covering medical treatment for severe mental illness commensurate with other illnesses and an assessment of the efficacy of treatment of severe mental illness.

Severe mental illness is defined through diagnosis, disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder. The Committee requests further that this report be transmitted to the Committee prior to next year's hearings as authorized under section 406(g) of the Public Health Service Act. (Senate Report No. 102-397, page 96)

The following report has been prepared by the National Advisory Mental Health Council (NAMHC) in response to this request.

BACKGROUND

One of the key questions confronting our Nation is how to provide affordable, appropriate health care for all Americans. As we rethink the structure and costs of health care in the United States, one essential goal must be to create a system that enables Americans with severe mental illnesses to obtain the care they need to function at their best. These individuals continue to suffer from misunderstanding, stigmatization, and inadequate societal resources -- a cruel and unnecessary addition to the burden of illness.

Contrary to persistent myth, mental illnesses are both real and definable. Thanks to research advances, the diagnosis and treatment of mental disorders have undergone dramatic improvements in recent years, enabling millions of people to recover quickly and return to productive lives. Furthermore, the great majority of people can now be treated on an outpatient basis. Even people who once would have spent much of their lives disabled and hospitalized can now live successfully in the community.

But for many people, especially many of those with severe mental illnesses, these advances are irrelevant. As the care system and its financing are now structured, inequitable allocation of health resources places many severely mentally ill individuals at an extreme disadvantage: They simply cannot access the services that would benefit them. We must do better in the coming years, and we can.

Improving the financial accessibility of mental health care, especially to those most in need of it, will yield both humane and economic benefits for our Nation. Millions of Americans with severe mental disorders will be able to participate more productively at home, at work, and in the community. Substantial numbers will no longer face the prospect of impoverishment before becoming eligible for the only public coverage they might obtain for treatment, namely, Medicaid. And finally, the enormous but often hidden costs of untreated severe mental illnesses -- which are now borne by the general health care system and society at large -- can be appreciably reduced.

The creation of a more rational and effective health care system requires a solid empirical understanding of what service needs exist, what treatments work for whom, what those treatments cost when delivered appropriately, and which treatments reflect good, cost-effective care. For people with mental disorders, much of this information already exists or is currently being developed through the research supported or conducted by the National Institute of Mental Health (NIMH). The NAMHC has drawn upon these data in the preparation of this report.

What follows is a brief overview of key findings germane to the Senate Appropriations Committee request, (and, wherever possible, consistent with the Committee's definition of severe mental illness), as developed through NIMH-supported research and data analyses (see Appendix B). Most of these data pertain primarily to adults, although some data about the prevalence, treatment, and costs of severe mental disorders in children are presented as well.

THE NATURE OF SEVERE MENTAL ILLNESSES

The term "severe mental illnesses" encompasses a group of discrete mental disorders that differ in cause, course, and treatment. Most of the disorders discussed in this report are long-lasting and produce significant levels of impairment, especially when optimal treatment is not available. (It is well to remember, however, that this toll continues to be diminished as scientific progress yields new clinical advances.)

No single image captures the functional meaning of severe mental illnesses for those struggling with their consequences. The lives of individuals with schizophrenia, manic-depressive illness, or obsessive-compulsive disorder are as varied as their ages, family incomes, service needs, and responsiveness to treatment and rehabilitation. This population includes a relatively small group of individuals whose symptoms are largely untouched by current treatments or rehabilitative efforts and who require life-long supervised living arrangements. (Included, as well, are some individuals -- such as many homeless people with severe mental disorders -- whose disability is exacerbated by long-term lack of treatment, physical illness, and/or substance abuse.) But the population of Americans with severe mental illnesses also includes many more people who, with appropriate diagnosis, treatment, and rehabilitation, can lead relatively normal, productive lives in the community.

PREVALENCE

During the past decade, our understanding of the epidemiology of mental disorders has taken a giant leap forward. The mental health field has developed increasingly explicit, research-based

diagnostic criteria for identifying and classifying discrete mental disorders (American Psychiatric Association 1987; Spitzer et al. 1978; World Health Organization 1992). It has also seen the growth of new, systematic ways to quantify the severity of illness and the extent of impairment it produces (American Psychiatric Association 1987; Shaffer et al. 1987; Endicott et al. 1976). These advances, coupled with important improvements in epidemiologic survey methodology (Eaton and Kessler 1985; Robins and Regier 1991), have made it possible to develop increasingly reliable national data on the prevalence of a wide range of mental disorders in the United States (Robins and Regier 1991; Regier et al. 1993). The following data selectively focus on the severe end of the spectrum of mental disorders.

Prevalence in Adults

The major source of prevalence data on mental disorders in the adult U.S. population is the Epidemiologic Catchment Area (ECA) program, a large epidemiologic survey (1981-1985) sponsored by NIMH (Regier et al. 1984). This data base is unique in several respects. It is the first epidemiology survey to yield reliable national estimates of discrete, diagnosable mental disorders. Because the ECA study incorporated a 1-year follow-up, it provides data on changes in mental health status over time. And because it also surveyed services use, it offers a picture of which individuals, with which diagnoses, use which service providers, and with what frequency.

- o Mental disorders affect 22 percent of the U.S. adult population in a 1-year period (Regier et al. 1993) (see Figure 1, Appendix A), a rate below or comparable to that for various groups of "physical" disorders, such as respiratory disorders at 50 percent (National Center for Health Statistics 1986), and cardiovascular disorders at 20 percent (National Center for Health Statistics 1972). Many of these mental disorders are relatively brief in duration; less than 7 percent of U.S. adults have mental disorders that persist at full diagnostic levels 1 year or more (Regier et al. 1993). Other studies reveal that only 9 percent of adults report significant disability (defined as a Global Assessment Scale score of less than 70) associated with mental disorders (Regier et al. 1985).
- o Between 2 and 3 percent of U.S. adults are affected by severe mental disorders. Specifically, the ECA data reveal that in a 1-year period, 2.8 percent of the U.S. adult population--or approximately 5 million people in 1990--would meet the severe mental illness criteria outlined by the Senate Appropriations Committee's definition (National Institute of Mental Health, unpublished) (see Table 1, Appendix A).

Although the ECA prevalence data were gathered almost a decade ago, they are in the same range as those from more recent studies. Thus, the 1992 NIMH-sponsored National Comorbidity Survey (NCS), directed by Ronald Kessler of the University of Michigan and based on a national sample of over 8,000 households (including all members ages 15-54), has estimated that severe mental illnesses (defined in accord with the Appropriations Committee criteria) affect 3.2 percent of this somewhat younger and more high-risk population (Kessler, unpublished). In addition, in an NIMH-sponsored supplement to the Health Interview Survey (HIS), conducted in 1989 by the National Center for Health Statistics (NCHS), 2.1 to 2.6 percent of the U.S. adult population were identified as having "serious mental illness," as indicated by diagnosis and disability (Barker et al. 1992).*

* NOTE: This study defined "serious mental illness" as "any psychiatric disorder present during the past year that seriously interfered with one or more aspects of a person's daily life."

Another indicator of the size of the population with severe mental illnesses is provided by data from the Social Security Administration. The severely mentally ill population includes a core group of individuals so impaired that they qualify for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). In 1991, 0.5 percent of the national population (or about 1 million individuals) received support benefits because of a severe mental disorder (Kennedy and Manderscheid 1992). (This represents 18 percent of the severely mentally ill population.) Among disabled workers receiving SSDI benefits, 24 percent did so on the basis of mental disorders, as did 27 percent of SSI recipients.

Prevalence in Children

Epidemiologic data on the prevalence of mental disorders in children in the U.S. are not yet as well developed as they are for adults (Institute of Medicine 1989). Nonetheless, preliminary data from the 1992 NIMH Cooperative Agreement for Methodologic Research for Multi-site Epidemiologic Surveys of Mental Disorders in Child and Adolescent Populations (MECA) permit some estimates to be made, although they cannot be generalized to the population at large.

- o The MECA data indicate that 3.2 percent of the sampled population of children ages 9-17 have a severe mental disorder (as defined by the Senate Appropriations Committee) in a 6-month period (National Institute of Mental Health, unpublished).

TREATMENT EFFICACY*

For people with severe mental disorders, the chances of obtaining significant benefit through treatment have never been better. Millions of Americans, however, are largely unaware that over the past two decades, the therapeutic options available to clinicians for treating specific mental disorders have become more numerous, more specific, and more effective. Treatment alternatives now exist for many severe mental disorders.

Equally unknown by many outside the field is the fact that a growing body of research knowledge from clinical trials has verified the efficacy of these treatments for specific disorders, and has provided a useful scientific basis for clinical decision-making (see Figures 2 and 3). Indeed, of the available treatments for mental illnesses, the majority are supported by extensive controlled clinical trials. This compares very favorably with other areas of medicine.

Further, the efficacy of many treatments for severe mental disorders is comparable to that in other branches of medicine, including surgery. Note, for example, in Figure 2 that the 6-month success rates for angioplasty and atherectomy are well below the rates for early response to treatments for most severe mental illnesses.

To aid in assessing this body of knowledge and identifying new research directions, NIMH, at the request of NAMHC, recently commissioned a cluster of overviews of the treatment efficacy literature concerning the following major topics: schizophrenia (Schooler and Keith); major depression (Frank and Karp); manic-depressive illness (bipolar disorder (Gelenberg)); panic disorder (Ballenger); obsessive-compulsive disorder (Jenike); geropsychiatric disorders (Schneider); disorders of childhood (Klein and Slomkowski); and rehabilitation (Wallace). What follows are the key findings pertinent to the Appropriations Committee's request. (For the full reports, see Attachment: Reports on Treatment Efficacy.)

*NOTE: Information in this section is derived from scientific reviews of the literature presented in full within the Attachment: Scientific Reports on Treatment Efficacy.

SchizophreniaEstablished Treatment Efficacy:

Schizophrenia is an illness beginning in late adolescence or early adulthood in which psychotic features (hallucinations, delusions, and disordered thinking) and lost capabilities (loss of will, pleasure, and emotional range) are predominant. Clinical trials data of the past 30 years are in agreement that standard antipsychotic medications (e.g., chlorpromazine, trifluoperazine, haloperidol) initially reduce psychotic symptoms in 60 percent of patients and in 70 to 85 percent of those experiencing symptoms for the first time. However, even when medication is sustained, 60 percent of patients will subsequently relapse and require inpatient care. Adding specific psychosocial treatments to an active medication program can reduce the rehospitalization rate to 25 to 30 percent in a 2-year period. Particularly effective are psychoeducational treatment programs that give families skills for managing a member's illness. Further, the context and service system in which treatment is delivered are particularly important for those suffering from a psychotic illness (see Rehabilitation section below).

New Developments:

Although the antipsychotic medications and psychosocial treatments mentioned above can appreciably improve the lives of substantial numbers of people with schizophrenia, for 10 to 20 percent of all patients with this disorder, schizophrenia is a chronically deteriorating illness. New hope has arisen in the past 3 years with the availability of clozapine, a medication that is effective in nearly one-third of those previously unresponsive to all treatments. However, clozapine requires close patient monitoring for potentially life-threatening side effects (e.g., agranulocytosis). Additional medications (e.g., risperidone) that appear to have clozapine's beneficial effects without some of its serious side effects may well be introduced in the next year or two.

Manic-Depressive Illness (Bipolar Disorder)Established Treatment Efficacy:

People with manic-depressive illness experience cycling changes between extreme highs (mania) and extreme lows (depression). Episodes may recur within days, months, or years, with intermittent periods of normal moods. Many treatments now permit effective management of this severe and often persistent mental illness and enable people with bipolar disorder to lead essentially normal lives.

In treating acute episodes of mania, lithium has been shown to lessen symptoms within the first 10 days of illness; adding antipsychotic medications can hasten recovery. Electroconvulsive therapy (ECT) is even more rapidly effective than lithium during early treatment, especially for severely manic patients and those with mixed (manic and depressive) states.

Lithium is also a well-established and effective treatment for preventing recurrence of manic and depressive episodes, and it remains the standard of treatment. Psychosocial interventions that emphasize medication compliance are also critically important. Studies have shown that patients maintained on lithium after the acute episode of illness are 28 times less likely to relapse in a given month than those without the medication. For patients receiving lithium who nonetheless have "breakthrough" episodes of mania or depression, other antimanic or antidepressant medications have been shown to be effective.

New Developments:

Because of the obvious success of lithium, for many years it was believed that the problem of treating bipolar disorder had been solved. For the majority of patients, this was true. But for others, particularly those who cycled rapidly between mania and depression, for those with co-existing substance abuse, or those whose illness began in early adolescence, it was not. Special treatment approaches are being explored for these patient groups, as are some psychosocial approaches that are demonstrably effective in encouraging patients to comply with their medication regimes.

For patients with an unsatisfactory or incomplete response to lithium, use of the anticonvulsant drugs carbamazepine and valproate provides a promising new approach. Both medications have been shown to be effective in controlled studies of individuals unresponsive to lithium.

Major Depression

Established Treatment Efficacy:

Major depression, beyond affecting mood itself, contributes to loss of interest and pleasure, fatigue, feelings of worthlessness, suicidal ideation, and disturbances in bodily functioning, such as weight loss and insomnia. These symptoms are frequently all-pervasive and may last for long periods of time without treatment.

For the more severe forms of major depression, medication has been shown to be an essential component of treatment. Three classes of antidepressant medication offer many therapeutic options: tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and the newer heterocyclic antidepressants. Between 60 and 65 percent of patients obtain relief from their depression from the initial treatment with antidepressants. This rate rises to 80 to 85 percent with substitutions in medication or the addition of supplemental pharmacologic treatments. ECT remains a highly effective treatment for selected depressed patients who cannot tolerate or respond to antidepressant medication, or for whom a rapid response is imperative.

A variety of depression-specific psychotherapies -- cognitive therapy, behavior therapy, interpersonal psychotherapy, and brief dynamic psychotherapy -- have demonstrated efficacy with less-severe forms of depression. In addition, they have been shown to be useful as adjuncts to medication in treating the more severe forms of this disorder. Also, when combined with maintenance medication, psychotherapy may help delay or prevent recurrences of depression.

New Developments:

There is evidence that 65 percent of patients who do not respond to tricyclic antidepressants do respond to MAOIs. However, some have difficulty with the dietary restrictions required when using standard MAOIs (e.g., patients must eliminate all foods containing tyramine, such as beer, some red wines, fava beans, liver, and many aged cheeses). Clinical studies are now evaluating new MAOIs (e.g., moclobemide, brofaromine) that do not require these dietary restrictions.

The recent emergence of selective serotonin reuptake inhibitors (e.g. fluoxetine, sertraline, and paroxetine, a medication newly approved by the Food and Drug Administration), along with the chemically novel medication, bupropion, provides a new approach to depression with fewer side effects. These medications also offer an alternative for patients previously unresponsive to treatment. New evidence is accumulating, as well, regarding the importance of maintaining the initial response dosage levels of medication to enhance relapse prevention.

Panic Disorder**Established Treatment Efficacy:**

Often first seen in the family physician's office because of the sudden onset of feeling of impending death, people suffering from panic disorder experience discrete periods of intense fear or discomfort, accompanied by shortness of breath, dizziness, palpitations, sweating, choking, and chest pains. Often these symptoms assume such significance that people experiencing them can do little else. The treatment of panic disorder is one of the major successes demonstrated through clinical treatment research. Response rates of 70 to 90 percent have been reported with antidepressant medications such as tricyclics and monoamine oxidase inhibitors, as well as the anti-anxiety, high-potency benzodiazepines. Further, some, but not all, studies have reported that behavioral interventions, such as cognitive restructuring (designed to alter a patient's catastrophic perceptions), produce results comparable to those reported for medication.

New Developments:

Panic Control Treatment, a new behavioral approach, has produced response rates similar to those for medication and has demonstrated enduring effects over a 2-year followup. With this treatment, 50 to 60 percent of patients attain high overall functioning. Clinical trials are now underway examining the efficacy of this treatment in combination with medication.

Obsessive-Compulsive Disorder (OCD)**Established Treatment Efficacy:**

For many years, people suffering from obsessive-compulsive disorder (OCD) had very little hope of relief from their crippling rituals and obsessive thinking patterns. They were besieged by intrusive, senseless ideas and uncontrollable, repetitive behaviors driven by their own minds. Clinical studies report that only about 5 percent of patients have spontaneous recovery and that others may recover somewhat with behavioral treatments (up to 75 percent initially), but as they try to return to normal life patterns, their symptoms more often than not recur.

New Developments:

For patients with OCD, the prospect of improvement has brightened through the recent introduction of the tricyclic antidepressant clomipramine, as well as the selective serotonin reuptake inhibitors (e.g., fluoxetine, sertraline, paroxetine), all of which are now under study. With 80 percent of OCD patients showing some response to clomipramine and 60 percent at least a moderate response, and with the addition of behavioral therapy providing relief from rituals (particularly when additional booster sessions are given), these severely ill individuals have new grounds for hope.

Mental Disorders in Late Life**A. Depression****Established Treatment Efficacy:**

Extensive clinical trials research provides evidence that antidepressants are effective in treating acute depression in elderly patients. Approximately 60 percent of patients improve clinically with these medications, although many significant symptoms remain. When combined with interpersonal psychotherapy or cognitive behavioral therapy, the success rate rises to between 70 and 80 percent, as it does in other age groups. ECT

has also been established as the treatment of choice for severely immobilizing depression. High success rates (80 percent) have been reported for antidepressant maintenance treatment over a period of 1 1/2 years.

New Developments:

The side effects of the commonly used and effective tricyclic antidepressants (e.g. urinary retention, weight gain, constipation, hypotension) are of particular concern in an older patient population. Thus, considerable interest has been generated in new medications that are virtually free of these side effects, such as bupropion and the serotonin reuptake inhibitors, and results from clinical trials look quite promising.

B. Psychosis

Established Treatment Efficacy:

Neuroleptic (antipsychotic) medications are the most effective treatment for both early- and late-onset psychosis and are consistently used in older patients (see Schizophrenia, above).

New Developments:

The role of clozapine has not been completely established for use in older patients, but work is underway examining its efficacy in this group.

Disorders of Childhood and Adolescence

Established Treatment Efficacy:

Establishing effective treatments for the developmental, emotional, and behavioral symptoms of childhood mental disorders is an urgent task. These disorders have relatively high prevalence rates among children and adolescents, and the great majority of adult mental disorders -- many of which often co-occur with substance abuse -- originate in childhood or adolescence.

Many demonstrably effective treatments for these disorders are available or under development. For bipolar disorder in children and adolescents, the use of medication (lithium along with supplemental antidepressants or antipsychotics for breakthrough episodes of depression or mania, respectively) together with psychotherapeutic intervention is essential to restore normal functioning. For anxiety disorders (e.g., separation anxiety disorder, obsessive-compulsive disorder), psychotherapies (e.g., behavior therapy that involves the child and the family) as well as specific medications (clomipramine and fluoxetine) are effective. For autism, antipsychotics (haloperidol, thiorizadine, chlorpromazine) markedly reduce symptoms, while behavioral treatments enhance day-to-day functioning.

New Developments:

Because developmental factors have special impact on juvenile depression, research studies have attempted to clarify how this severe mental disorder resembles or differs from adult depression. Unfortunately, the response to tricyclic antidepressants has not been as positive in children as in adults. Other therapies (selective serotonin reuptake inhibitors, bupropion, MAOIs, and cognitive therapies) are just now beginning to be investigated, with promising early results. For the most severe forms of aggression and conduct disorder, there are encouraging studies evaluating early psychosocial interventions as well as the use of medications for some individuals.

Research has revealed the benefits of psychotherapeutic interventions for many disorders of childhood and adolescence. But a challenge remains to pinpoint further how well these treatments work, how they are best administered, how they compare and combine with specific medications, and how to achieve the best match between treatments and the individual needs of children and adolescents with severe mental illnesses.

Rehabilitation

The goals of treatment for people with severe mental illnesses must extend beyond symptom remission to rehabilitation. The lives of many such individuals were significantly disrupted at a time when they were trying to complete important developmental tasks such as advancing education and/or initiating a career. As with impairments produced by some physical illnesses, those produced by some severe mental illnesses may require extended rehabilitation. Programs that have focused on the full range of rehabilitation, from skills training to comprehensive community programs, have repeatedly demonstrated the necessity for ongoing availability of rehabilitation resources for this population.

Another critical principle, as noted in the Schizophrenia section, above, is the integration of the components of treatment and the context in which treatment is delivered. This principle is successfully illustrated by the Program of Assertive Community Treatment (PACT) model, which uses an intensively focused, multimodality treatment team to offer crisis intervention, formal education, community resource management, direct skills training, and employment assistance. Patient outcomes of the PACT model have included lower rates of hospitalization; increased independent living, employment, and social interactions; and greater satisfaction with life. These advances are maintained, however, only when the program is continuously available.

Cost-benefit analyses have shown that PACT provides both additional benefits and costs compared with conventional hospital-based treatment. However, the benefits (e.g., sheltered-workshop income and/or other earnings) significantly outweigh the costs of providing treatment. The PACT model has now been implemented on a State-wide basis in Delaware, Michigan, Rhode Island, Wisconsin, and Ohio; an additional 20 States have implemented at least several PACT teams.

Current research efforts are exploring ways to identify subgroups of patients who are particularly likely to respond to specific rehabilitative techniques. In addition, work is continuing to delineate clearly standardized methods for teaching skills and to develop better assessment methods to improve treatment decisions.

In summary, the treatments available for severe mental illness are effective for most patients, and can be delivered in a cost-efficient manner. As we extend our scientific data base into the future, we can expect the development of treatments that will further reduce symptoms and return functioning.

SERVICE USE

Health care for Americans with mental disorders is offered by a complex array of providers and organizations--public and private, on both an inpatient and outpatient basis (Narrow et al. 1993; Manderscheid et al. 1993). The ECA study, which provides a description of the use of health services by adults with severe mental disorders, reveals that, as with other types of illness, not all people with these disorders seek care, as illustrated by the following findings (see also Table 3):

Service Use by Severely Mentally Ill Adults

- o During a 1-year period, approximately 60 percent of the adult population with severe mental disorders (about 3 million people) sought outpatient care for those disorders in the health care system, either in the specialty mental health sector or in the general medical sector (Regier et al. 1993; National Institute of Mental Health, unpublished). (Components of these sectors are described in Appendix B.)
- o Of adults with severe mental illness, 17 percent (about 850,000 people) received any inpatient care in the health care system in 1 year (Narrow et al. 1993; National Institute of Mental Health, unpublished).

Service Use by Severely Mentally Ill Children

- o The MECA survey described on page 10 has revealed that, during a 1-year period, 29 percent of the children and adolescents in this population with severe mental disorders used outpatient mental health services, and 10 percent used inpatient services (National Institute of Mental Health, unpublished).

SOCIAL COSTS AND COSTS OF TREATMENT

An NIMH-sponsored study by Dorothy Rice (Institute for Health and Aging, University of California, San Francisco) provides the most recent available data on indirect and direct costs of mental illnesses (Rice et al. 1990, 1991; Rice and Miller, unpublished). Based on this study, key data focused on adults and children with severe mental disorders are presented (see also Table 4).

- o In 1990, the core indirect cost of severe mental illnesses in the United States was conservatively estimated at \$44 billion. This cost to society includes lost productivity and earnings due to illness, as well as lost earnings due to premature death.
- o The direct cost of treating severe mental illnesses was an estimated \$20 billion, with an additional \$7 billion for long-term nursing home care. (These costs occur in a context of \$67 billion direct cost for treatment of all mental illnesses (Rice, unpublished), which represents 10 percent of the total \$670 billion direct cost of all health care in the U.S. in 1990 (Levit et al. 1991).)
- o The other related costs of severe mental illnesses (which include social welfare administration, criminal justice, and family caregiving) were an estimated \$4 billion. Other sources, specifically, studies conducted from a public finance perspective, indicate that about one-quarter of all Social Security disability payments are for individuals with severe mental disorders (Kennedy and Manderscheid 1992; Rupp 1993).
- o The total costs (core costs--direct and indirect--plus other related costs) of severe mental illnesses in 1990 were estimated to be \$74 billion. (For all mental disorders the total costs were \$148 billion (Rice, unpublished), in contrast to \$159 billion in the same year for all cardiovascular system diseases (National Heart, Lung, and Blood Institute, unpublished).)

As noted above in the Service Use section, only 60 percent of people with severe mental illnesses now obtain treatment within the health care system in a 1-year period. Presumably, a substantial proportion of the indirect cost of severe mental illnesses can be attributed to the relatively large population that is now untreated. Given the effectiveness of current treatments for these disorders, it seems likely that improved

access to treatment would decrease indirect costs, possibly offsetting increases in direct costs (see Benefits of Commensurate Coverage, below).

FUNDING SOURCES FOR MENTAL HEALTH CARE

Within the overall health care delivery system, the mental health system relies upon an unusually high proportion of funds from State and local governments. As shown in Figure 7, in the overall health care system only 14 percent of total expenditures are derived from State, local, and other (non-Medicaid or Medicare) governmental sources (Levit et al. 1991). In contrast, as seen in Figure 8, these sources represent 28 percent of all funding sources for mental health care (Rice et al. 1990).

As seen in Figure 6, among the U.S. adults with severe mental disorders, 64 percent have some private insurance, and only 18 percent have Medicaid or other government coverage (Kessler, unpublished). However, as shown in Figure 9, looking at expenditures for those who seek care for their severe mental disorders, State and local government programs account for 31 percent of expenditures for this population, and Medicare and other Federal programs account for 26 percent; combined they represent a public share of 57 percent (Rice and Miller, unpublished) (compared to 42 percent of all health costs, as shown in Figure 7).

CURRENT INEQUITIES IN INSURANCE COVERAGE

Research studies have revealed a key characteristic of the mental health service system and its financing: Health insurance coverage for the diagnosis and treatment of mental disorders is usually not comparable to coverage for other diseases. Some examples follow (Blostin 1987; Bureau of Labor Statistics 1990; Taube et al. 1990; Lave and Goldman 1990; Rupp 1991).

Private Insurance Coverage

A wide variety of plans provide employer-based private insurance coverage for the treatment of mental disorders. The following findings, based on data from the mid-1980s from the Bureau of Labor Statistics (BLS), are illustrative:

- o Of employees in large and medium-size firms, roughly 79 percent of participants in plans with any mental health benefits had more restrictive hospital coverage for mental illnesses than for other illnesses.
- o For about half of the participants, coverage for hospitalization was limited to 30 to 60 days per year for mental illnesses, compared with 120 days or unlimited days for physical illnesses. About 38 percent of all participants belonged to plans that impose an additional or separate lower maximum on annual expenses, such as a lifetime maximum of \$50,000 on all mental health benefits.
- o Outpatient psychiatric care coverage was limited in 95 percent of the health insurance plans surveyed. Among participants, 34 percent had fewer outpatient visits covered annually for mental disorders than for other disorders, and 66 percent had special maximum annual payment limits imposed on mental health visits.

Managed-care settings also place discriminatory limits on treatment of mental disorders, as indicated by a 1985 NIMH-sponsored survey of 473 health maintenance organizations (HMOs) (Peterson et al. 1992). For example, the average inpatient

mental health benefit was 34 days per year; the outpatient mental health benefit was 21 visits per benefit period. These restrictions generally were not applied to other health care offered in HMOs.

Public Coverage

Among people with severe mental disorders who use services, public insurance programs account for an estimated 18 percent of all coverage (see Figure 6). Key among these are the Medicare and Medicaid programs, whose mental health coverage provisions and State Mental Health Authority programs are described in Appendix C. As with private insurance, these public programs also place more limitations on mental health care than on other health care.

- o The Federal Government has incorporated lower coverage levels for mental health services than for other health services in the design of the Medicare program (Taube 1990). Although recent legislation has improved the situation somewhat, there are still remnants of discriminatory mental health coverage. For example, outpatient treatment of mental disorders requires 50 percent copayment by the patient, compared with 20 percent copayment for other medical outpatient treatment (Sherman 1992).
- o The Medicaid program maintains a historical exclusion in which individuals ages 22 to 64 years in an "institution for mental disease (IMD)" may not receive Federal funding for any psychiatric or other medical care (Koyanagi 1988).

COSTS OF COMMENSURATE COVERAGE

In response to the Senate Appropriations Committee's request for information on the cost of covering medical treatment for severe mental illness commensurate with other illnesses, the National Advisory Mental Health Council requested that NIMH commission and perform special economic analyses that would permit such cost estimates to be obtained.

In developing an estimate of the total cost of "commensurate" coverage for people with severe mental disorders, NIMH staff assumed that the total cost would include both those insured under the private insurance sector and those under the public sector. Analyses were based on studies of services utilization and costs, using data from both private and public sources of funding. (The sources and methodologies for developing all data presented in this section are discussed in Appendix B.)

Data from the National Comorbidity Study indicate that 64 percent of people with severe mental disorders have private insurance (Kessler, unpublished). As noted above, these private insurance plans rarely adequately cover treatment for mental disorders.

But under proposed health care reform, these plans would have to cover such treatment "commensurate" with other illnesses. This change would shift the cost of treatment for mental disorders from the public sector or out-of-pocket payments to the private system.

Analyses of MEDSTAT data on private insurance costs and utilization were conducted by an economic research group at The Johns Hopkins University. These studies show that the average expenditure under a full-coverage private insurance plan during 1 year (1990) for each person with a severe mental disorder was \$7,462 (Frank, unpublished). Thus, assuming that approximately 3.3 million people (64 percent of the 5.1 million people with severe mental disorders) would be covered by an expanded private insurance plan, the direct cost of commensurate coverage for them would be \$24.6 billion.

The National Comorbidity Survey reveals that the remaining 36 percent of people with severe mental disorders are potentially covered by the public sector (Kessler, unpublished). As a basis for estimating a cost of commensurate coverage for this segment of the population, a public insurance plan providing full coverage (during the mid-1980s) was chosen: the Michigan Medicaid program. An analysis of this program at the Health Care Financing Administration (Wright and Buck 1991) showed that the average annual expenditure for each person with severe mental disorders was \$3,528 (inflated to 1990). Thus, assuming that 1.8 million people (36 percent of the 5.1 million people with severe mental disorders) would be covered by an expanded public insurance plan, the direct cost for these people would be \$6.4 billion.

If one combines the two costs above (i.e., direct costs for expanded private and public insurance coverage), then the total cost for "commensurate" coverage of adults with severe mental disorders would be \$31 billion. However, this estimate would assume, incorrectly, that the total population covered would use the system during the year. Currently 60 percent of people with severe mental disorders use services during a given year; this number would probably increase to about 80 percent with full coverage. (The 80 percent estimate is based on data from the RAND Health Insurance Experiment (Wells et al. 1982), which would suggest an increase of approximately 20 percent in utilization under the type of coverage estimated in this report. This would more closely approximate the 80 percent yearly utilization rate now seen for people with cardiovascular disorders.) Thus, the direct cost for commensurate coverage for adults should be approximately \$24.8 billion in 1 year (80 percent x \$31 billion).

The cost for "commensurate" coverage of children with severe mental disorders is more difficult to estimate (see Appendix B for methodology). Expenditure estimates for care of this population and the treatment settings used by children vary widely. Therefore, cost estimates for this segment of the population were based on assumptions used for the adult population. The direct cost for commensurate coverage of children would be \$1.7 billion.

Based on the above estimates, the direct cost for commensurate coverage of both adults and children with severe mental disorders would be \$26.5 billion. Given current expenditures (1990) excluding nursing homes, this would represent an extra \$6.5 billion needed each year to provide such coverage. It is important to note that if private insurance plans were required to provide commensurate coverage as assumed here, most of this increase would be borne by the private sector.

BENEFITS OF COMMENSURATE COVERAGE

In addition to the humanitarian benefits of providing commensurate coverage, there would also be economic benefits. The indirect costs, such as mortality and morbidity, should be reduced if people are able to obtain treatment. In addition, costs for administration of social welfare payments and use of the criminal justice system should decline.

Assumptions applied in calculating the economic benefits were adopted or derived from various cost-benefit evaluations of pharmaceutical interventions, therapies and treatment settings, and packages of treatment (e.g., Reifman and Wyatt 1980; Weisbrod et al. 1980; Stoudemeier et al. 1986; Kamlet et al. 1992; Frank 1981, 1992; Hu and Jerrell 1991; Drummond et al. 1987; Ruhm 1992; McDonnell Douglas 1990; Olsson, 1990; Kane et al. 1988; National Institute of Mental Health, 1988).

As shown in Appendix B, the annual savings in indirect costs amount to approximately \$7.5 billion. In addition, savings in general health care costs as a result of treatment of mental disorders was also estimated based on empirical data from a

large-scale medical offset study (Strain et al. 1991). The expectable 10 percent reduction in general health care costs will result in a potential \$1.2 billion savings.

The total annual savings in indirect costs and general medical services would amount to approximately \$8.7 billion. This would represent a net economic benefit of approximately \$2.2 billion (\$8.7 billion minus \$6.5 billion).

In summary, a solid body of research evidence supports the provision of commensurate coverage for people with severe mental illnesses. Greater access to treatments of demonstrated effectiveness will help these individuals function more productively. As a result, they, their families, and our Nation as a whole will benefit. That benefit can be realized in the context of the actions by the President and the Congress on health care reform later this year.

Health Care Reform
For Americans with Severe Mental Illnesses:
Report of the National Advisory Mental Health Council

APPENDIX A: FIGURES AND TABLES

TABLE 1: PERCENT OF ADULTS WITH SEVERE MENTAL DISORDERS

Diagnosis	% of U.S. Adult Population (Ages 18 and Above)
Schizophrenia	1.5
Manic Depressive (Bipolar)	1.0
Major Depression	1.1
Panic	0.4
Obsessive Compulsive	0.6
Any of Above	2.8*

* A person may carry more than one diagnosis at the same time. In this table these persons are counted once for each diagnosis and are included in more than one row of the table. The percentages for each individual diagnosis cannot be added together to obtain the total percentage of the population with any disorder.

Source: NIMH ECA, Unpublished Data.

TABLE 2: PERCENT OF CHILDREN AND ADOLESCENTS WITH SEVERE MENTAL DISORDERS

Diagnosis	% of Study Population (Ages 9-17)
Schizophrenia	1.2
Manic Depressive (Bipolar)	1.2
Major Depression	1.2
Panic	0.3
Obsessive Compulsive	0.6
Any of Above	3.2*

* A person may carry more than one diagnosis at the same time. In this table these persons are counted once for each diagnosis and are included in more than one row of the table. The percentages for each individual diagnosis cannot be added together to obtain the total percentage of the study population with any disorder.

Source: NIMH MECA, Unpublished Year 2 Data.

TABLE 3: PERCENT OF ADULTS WITH SEVERE MENTAL DISORDERS IN TREATMENT BY SERVICE SECTOR, IN ONE YEAR

	ANY SEVERE MENTAL DISORDER	SCHIZOPHRENIA	BIPOLAR	MAJOR DEPRESSION	PANIC	OBSESSIVE COMPULSIVE DISORDER
SPECIALTY MENTAL HEALTH SECTOR	43.6	45.6	39.8	64.5	55.0	39.8
GENERAL MEDICAL SECTOR	32.6	33.7	40.6	34.2	50.5	28.1
HEALTH SYSTEM TOTAL	62.4	64.5	65.4	79.1	79.8	34.1

Source: NIMH MECA, Unpublished Data.

Note: People may carry more than one diagnosis at the same time and may receive treatment in either or both the specialty mental health and/or general medical sectors. The percentages for each diagnosis within each service sector cannot be added together to obtain the total percentage of the population in the total health system.

**TABLE 4: ESTIMATED TREATMENT AND SOCIAL COSTS
OF SEVERE MENTAL DISORDERS, 1990
(IN MILLIONS)**

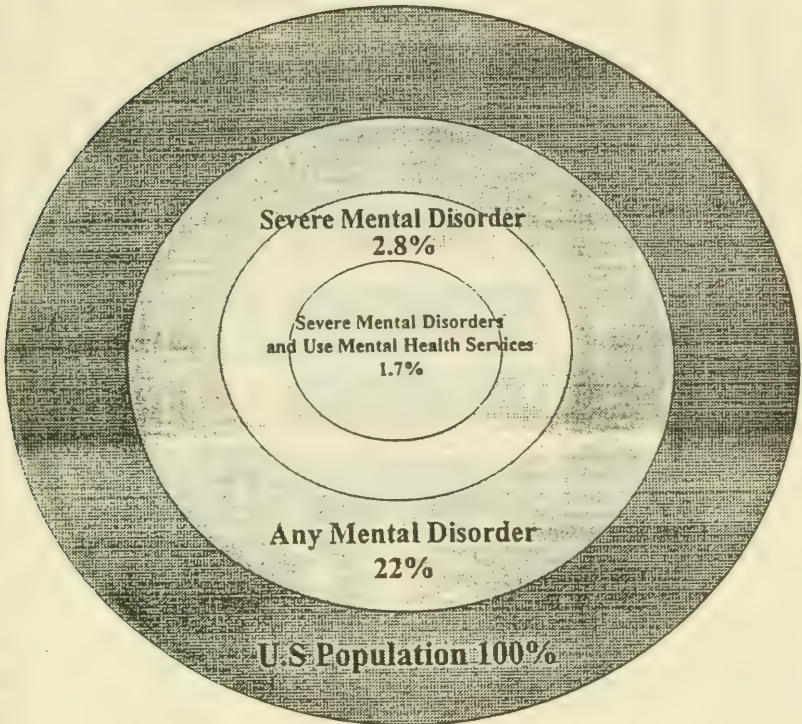
Type of Cost	Amount
Direct	26,551
Mental Health Organizations	7,931
Federal Provider	696
State and County Psychiatric Hospitals	3,766
Private Psychiatric Hospitals	2,476
Other ¹	983
General Medical Hospitals	6,862
Office-Based Physicians	729
Other Professional Services	1,317
Nursing Homes	6,585
Drugs	1,095
Support Costs	2,042
Indirect Costs	43,473
Morbidity	33,488
Noninstitutionalized Population	31,266
Institutionalized Population	2,222
Mortality ²	9,985
Other Related Costs	3,460
Criminal Justice System	649
Social Welfare Administration	335
Family Caregiving	2,476
Total	\$73,484

Source: Rice and Miller, Unpublished Data.

¹Includes residential treatment centers for emotionally disturbed children, freestanding alcohol, drug and mental health care organizations, multi-service mental health organizations, and correctional facilities.

²Discounted at 6 percent.

Figure 1. Percent of Adult Population with Mental Disorders, and Severe Mental Disorders, Including Users of Mental Health Services In One Year



Source: NIMH ECA, Unpublished Data.

Treatment Efficacy Early Treatment Outcome

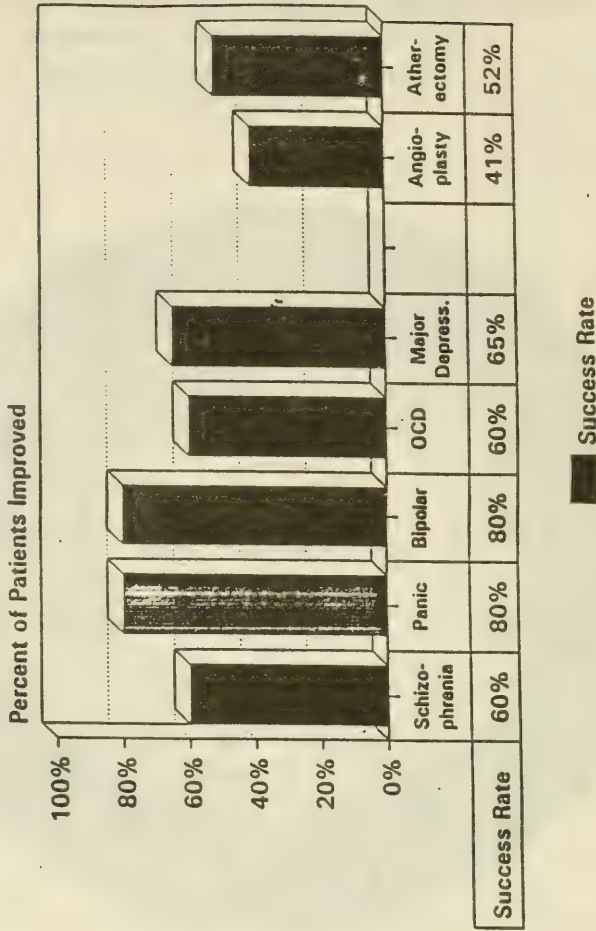


Figure 2.

Treatment Efficacy Long-Term Outcome

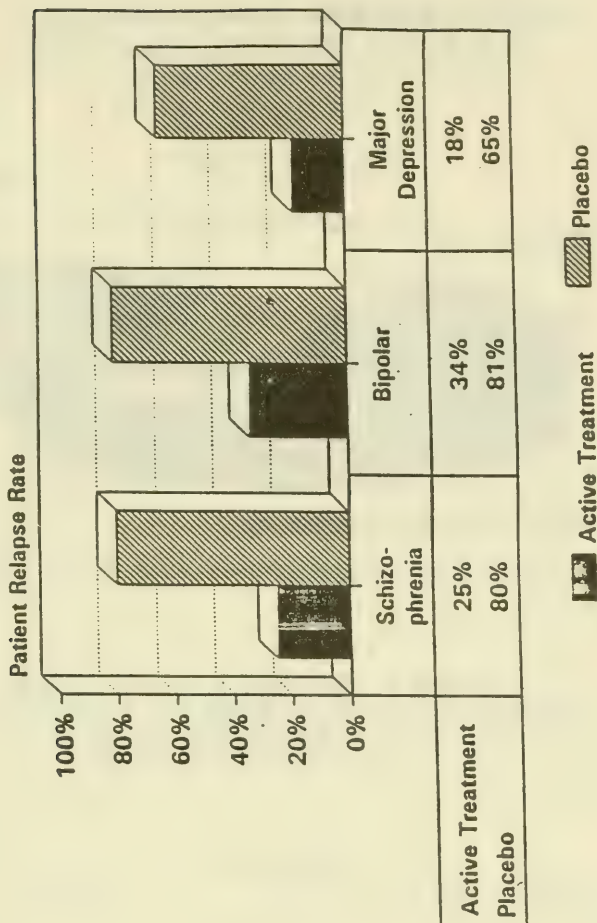
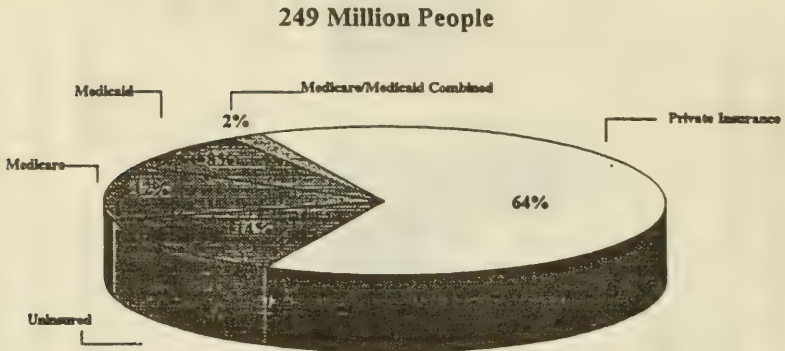


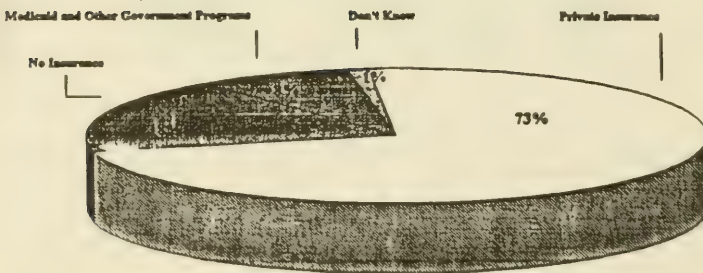
Figure 3.

**FIGURE 4. COVERAGE
FOR TOTAL U.S. POPULATION (1990)**



Source: Estimates based on U.S. Bureau of the Census, 1991.

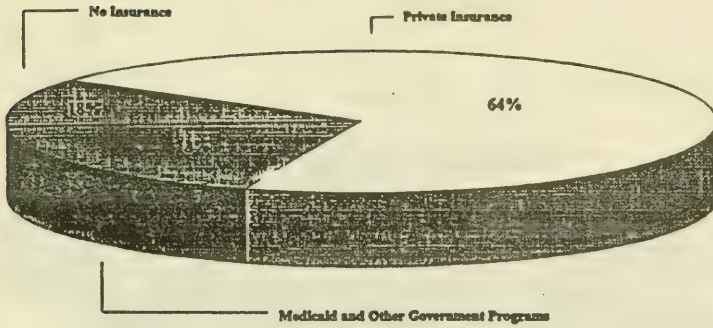
**FIGURE 5. COVERAGE FOR ALL PEOPLE
WITH
MENTAL DISORDERS**



Source: Kessler, Unpublished Data.

Note: All people with mental disorders constitute 20-22% of the total population in one year (NIMH ECA, Unpublished Data; Kessler, Unpublished Data).

FIGURE 6. COVERAGE FOR ALL PEOPLE WITH SEVERE MENTAL DISORDERS

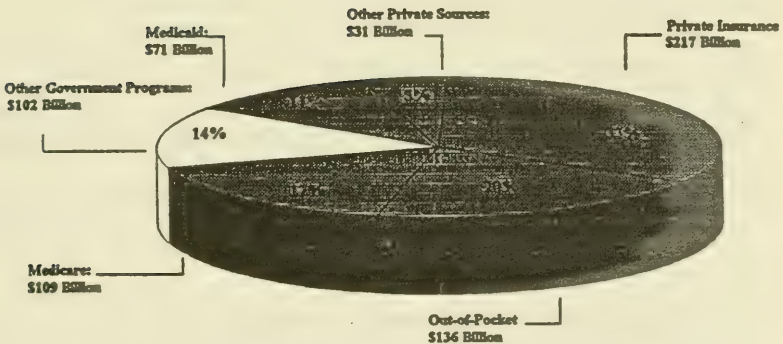


Source: Kessler, Unpublished Data.

Note: All people with severe mental disorders constitute 2-3% of the total population in one year (NIMH ECA; Unpublished Data; Kessler, Unpublished Data).

FIGURE 7. HEALTH CARE EXPENDITURES FOR TOTAL U.S. POPULATION (1990)

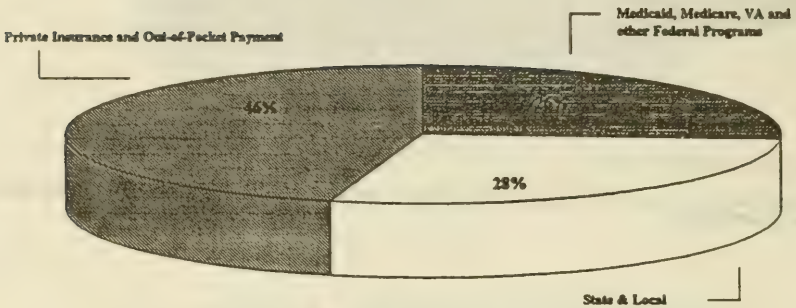
\$666 Billion



Source: Levit, K., Lazenby, H., Cowen, C., and Letsch, S., 1991.

**FIGURE 8. MENTAL HEALTH CARE EXPENDITURES
FOR ALL PEOPLE
WITH
MENTAL DISORDERS**

\$67 Billion

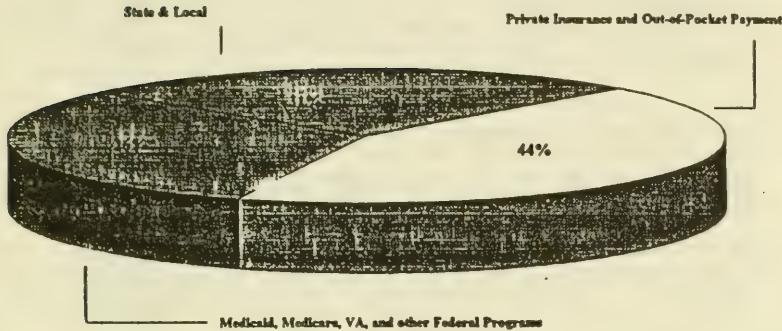


Source: Rice et al., 1990.

Note: All people with mental disorders who use specialty or general medical mental health services in one year constitute 9-10% of the total population in one year (NIMH ECA, Unpublished Data; Kessler, Unpublished Data).

FIGURE 9. MENTAL HEALTH CARE EXPENDITURES FOR ALL PEOPLE WITH SEVERE MENTAL DISORDERS

\$27 Billion



Source: Rice and Miller, Unpublished Data.

Note: All people with severe mental disorders who use specialty or general medical mental medical services in one year constitute 1.7% of the total population in one year (NIMH ECA, Unpublished Data).

APPENDIX B: DEFINITIONS AND METHODOLOGY

Epidemiologic Data

Operationalizing "Severe Mental Disorders"

The population of adults and children with severe mental disorders described in this report reflects the language of the Senate Committee on Appropriations' request to the National Advisory Mental Health Council. The mental disorders included here are those commonly accompanied by psychotic symptoms (e.g., schizophrenia, schizoaffective disorder, manic-depressive disorder* (bipolar mood disorder), and autism), and the severe forms of major depression, panic disorder, and obsessive-compulsive disorder. Wherever possible, criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) (American Psychiatric Association 1987) were used as the basis for making diagnoses. Corresponding diagnoses from the International Classification of Diseases (ICD-9) (World Health Organization 1977) were used as necessary.

Severity criteria were defined in the domains of recent receipt of treatment, symptomatology, and social/occupational/school functioning. Diagnostic information and criteria for severity were applied to five data sets in the following way:

* Manic-depressive disorder is known in DSM-III-R as bipolar mood disorder. For the purposes of this report, bipolar mood disorder was subcategorized into type I and type II. Bipolar disorder type I is characterized by the occurrence of a manic episode. Bipolar type II is characterized by occurrence of a hypomanic episode, which by definition produces less impairment than a manic episode (National Institute of Mental Health, unpublished).

- o For individuals who were diagnosed with schizophrenia, schizoaffective disorder, bipolar mood disorder type I, or autism within the year prior to the study's data collection, no additional indicator of severity was required to designate them as severely mentally ill. DSM-III-R criteria for schizophrenia, bipolar disorder type I, autistic disorder, and, by inference, schizoaffective disorder, require marked disturbance in functioning during an active episode of illness.
- o For individuals who had received a diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, or autistic disorder at some other point during their lives, but who did not reach diagnostic criteria during the past year, further evidence was required to assure their appropriate inclusion in the severe mental disorders group.

For this group, evidence of severity included at least one of the following within the past year: any inpatient psychiatric hospitalization or nursing home placement; any outpatient mental health treatment in a specialty mental health or general medical setting; psychotic symptomatology (criterion A of DSM schizophrenia); use of antipsychotic medication; or a Global Assessment of Functioning (GAF) Scale rating of 50 or less (i.e., functioning at or below the level of "serious symptoms or any serious impairment in social, occupational, or school functioning") (American Psychiatric Association 1987).

- o Individuals diagnosed with major depression, bipolar type II disorder, panic disorder, or obsessive-compulsive disorder during the previous year (or at any point in the individual's lifetime for persons with bipolar type II disorder) were considered severely mentally ill if there was evidence of severity in the past year. Evidence of severity for this group included inpatient psychiatric hospitalization; psychotic symptomatology; use of antipsychotic medication; or a GAF rating of 50 or less.

The definition for severe mental disorders in children and adolescents required one modification when it was applied to epidemiologic data sets. Recent research has shown that accurate psychiatric diagnoses of children in community surveys require an assessment of the level of impairment resulting from the reported symptoms (Bird et al. 1988). This is especially important for the psychotic disorders, for which standardized measurement in the community is still relatively unrefined. Therefore, for children and adolescents who reported symptoms consistent with a past-year history of schizophrenia, bipolar disorder, schizoaffective disorder or autism, severity criteria were also applied.

This definition of severe mental disorders in adults and children, as well as the method by which it was put into operation, were intended to include individuals with severe mental disorders as specified by the request from Congress. The definition and methodology are not intended to designate eligibility for coverage under health care reform programs.

Service Use Data

People with severe mental disorders seek both inpatient and outpatient care for those disorders within the health care system. As a group, they use general health care facilities and practitioners as well as specialized mental health facilities and practitioners for that care. In developing the services utilization data presented in this report, the following components of the health care system were examined (Eaton and Kessler 1985; Narrow et al. 1993; Regier et al. 1993):

Components of the Ambulatory Mental Health Care System

o Specialty Mental Health Sector

Psychiatric Hospital Outpatient Clinics
 Mental Health Center Outpatient Clinics
 General Hospital Outpatient Clinics
 Veterans' Affairs Hospital Outpatient Clinics
 Alcohol and Drug Treatment Outpatient Clinics
 Mental Health Specialists in Health Plans or Family Clinics
 Mental Health Specialists in Private Practice
 Crisis Centers

o General Medical Sector

General Hospital Emergency Departments
 General Medical (non-Psychiatrist) Physicians

Components of the Inpatient Mental Health Care System

General Hospitals (Psychiatric Units and Scatterbeds)
 State and County Mental Hospitals (includes Residential Supportive Care)
 Community Mental Health Centers
 Private Mental Hospitals
 Veterans' Affairs Hospitals Psychiatric Units
 Alcohol and Drug Treatment Units
 Nursing Homes

Cost DataPrivate Insurance Coverage:

In response to the Appropriations Committee's request for information on "the cost of covering medical treatment for severe mental illness commensurate with other illnesses," Council has requested that NIMH commission and conduct special economic analyses that permit a variety of such cost estimates to be developed. One such analysis is based on a broader NIMH-funded study by Richard Frank of The Johns Hopkins University, who is creating simulations of mental health service use and costs under various benefit packages (including those providing inpatient and outpatient coverage for mental disorders comparable to coverage for other disorders). The simulations have adopted a set of principles that were developed after reviewing the scientific research literature on the demand for and supply of mental health services (Frank et al. 1992). The simulation model was calibrated by McGuire (1992).

The simulations are based on analysis of mental health service utilization and costs, using a large data base: 1.5 million individuals who are associated with 25 mid-size to large firms throughout the United States whose private health insurance is part of the MEDSTAT claims processing system. This population represents approximately 40 percent of the employed U.S. population and their dependents who have insurance coverage -- approximately 100 million individuals.

Important broad goals of this study include identifying the costs of a benefit for severe mental disorders in both the public and private sectors, examining the interaction of these sectors, and helping to redefine the role of the public sector.

An initial set of estimates has been developed that focuses solely on private-sector coverage of severe mental disorders. It examines insurance plan costs of severe mental illness as defined by the Appropriations Committee.

The costs of several very simple benefits options for coverage of mental health care are determined:

o Full coverage (Baseline): In the MEDSTAT data, the average copayment level for outpatient care is 20 percent, while average inpatient coverage generally involves no cost-sharing and unlimited days paid under a negotiated per diem.

o Limited Coverage: Outpatient coverage is defined as requiring a 50 percent copayment, but no limits on visits or expenditures. Inpatient coverage consists of no copayments or deductibles, but a 30-day limit on hospital duration per year.

o Mixed Coverage: This alternative calls for full coverage of the severely mentally ill population and limited coverage of all other beneficiaries.

Costs of Commensurate Coverage

In developing the costs of commensurate coverage for people with severe mental disorders, the following calculations were made:

Adults

2.8% of 184 million U.S. adults have severe mental disorders	= 5.1 million
64% are covered by private insurance	= 3.3 million
35% are covered by public sector	= 1.8 million

private costs: 3.3 million x \$7,462/person/yr = \$24.6 billion

Public costs: 1.8 million x \$3,528/person/yr = \$6.4 billion

Direct costs = \$31.0 billion

[This assumes 100 percent utilization during a year. A more reasonable estimate of use with full coverage would be 80 percent. Thus, the total direct costs would be approximately \$24.8 billion (.80 x 31).]

Children:

3.2% of 31 million U.S. children ages 9-17 have severe mental disorders	= 992,000 children
64% covered by private insurance	= 645,000
36% covered by public sector	= 347,000

Private costs: 635,000 x \$7,462/person/yr = \$4.7 billion

Public costs: 357,000 x \$3,528/person/yr = \$1.3 billion

Total = \$6.0 billion

[This assumes 100 percent utilization during a year. However, studies show very low utilization for children, with a recent study showing a figure of around 29 percent National Institute of Mental Health, unpublished). Thus, the direct costs would be \$1.7 billion (.29 x 6).]

Total direct costs (adults @ children) = \$26.5 billion

Current direct treatment expenditures are \$20 billion (excluding nursing home costs). Thus, it would require another \$6.5 billion to provide commensurate coverage for adults and children with severe mental disorders.

Several caveats should be noted regarding the estimates described above. First, when considering the public-sector costs, expenditures from the State budget were not factored into the estimate of costs for patients in the public sector. Those expenditures are already part of current expenditures, and there is no current plan to shift State expenditures into Federal programs such as Medicaid. However, if commensurate coverage is mandated for those holding private insurance plans, a large part of the costs currently provided in the public sector will shift to the private sector for those people.

Second, the direct cost estimate does not include the cost for treating children under age 9 with severe mental disorders. There are no current data to indicate the size of this population. Among the severe mental disorders under consideration in this report, the only one likely to be found in this youngest age group is autism. Because the prevalence of that disorder is low, the added cost would probably be very small relative to costs of the other age groups.

Economic Benefit of Commensurate Coverage

Reduction in mortality costs. Premature death due to severe mental illness is the ultimate loss, and is estimated as the current monetary value of future output lost due to premature death. In the case of severe mental illness, suicide is responsible for the majority of deaths. In assessing the benefits of an equitable benefit package that allows the treatment of additional patients and/or provides more adequate treatment of patients who already have contact with the delivery system, it is assumed that one-third of the individuals treated will be treatment resistant while the other two-thirds will be treated successfully, thus avoiding premature death. Thus, two-thirds of deaths related to mental illness -- primarily suicides -- will be avoided, averting about 12,800 premature deaths in a year, and restoring about \$5.2 billion in lost lifetime earnings to the national economy.

The average number of productive years lost due to premature death is an estimated 30 years, given that one-third of suicides occur in the relatively young age group of 25 to 44 years. (Of note, however, is that death related to severe mental illness does occur in any age group, including children under the age of 15 years, and in the elderly. These individuals are reflected in calculating the cost of mortality.) Averting 12,800 deaths in a given year restores about \$0.2 billion in each year to the economy in the form of earnings.

Reduction in morbidity costs. In the human capital-based cost-of-illness studies, morbidity costs are the value of goods and services not produced in a given year because of the illness. The following morbidity costs calculations are based on ECA data (National Institute of Mental Health, unpublished data).

It is estimated that the average annual wage loss per person with severe mental illness is \$6,442. Of the 5.1 million individuals with severe mental disorders, it is also assumed that 20 percent will not receive treatment, resulting in a morbidity cost of \$6.4 billion for 1 million untreated individuals. Assuming that one-third of the remaining 4.1 million people with severe mental disorders will not be successfully treated, the morbidity cost will be \$9 billion for those 1.4 million people. Half (or 1.4 million) of the remaining 2.8 million individuals will be treated successfully, resulting in a \$9 million reduction in morbidity costs, with half of that gain (\$4.5 million) being realized during the first year of treatment. The remaining 1.4 million individuals will be partially successfully treated, and their annual average wage loss per person will be reduced by 50 percent, resulting in a \$4.5 billion reduction in morbidity costs over a 2-year period. Of that savings, \$2.3 billion will be realized in the first year.

The effect of commensurate coverage on the morbidity due to severe mental disorders is an increase in individuals' productive capacity and a reduction of \$6.8 billion per year.

Reduction in criminal justice system costs. When people with severe mental illnesses receive adequate treatment, it can be assumed that the crime-related costs of these disorders can be reduced by 50 percent. Crime-related costs include private and public expenditures for police protection, legal and judicial services, and correctional institutions. The 50 percent reduction will result in an annual savings of \$246 million (or \$0.2 billion). This figure assumes that 80 percent of those with severe mental disorders will seek treatment, and that two-thirds of those individuals will be treated successfully.

Reduction in social welfare administration costs. The same assumptions as above are made in estimating cost savings to the social welfare administration. These assumptions permit a reduction in costs of another \$0.2 billion.

Reduction in incarceration costs. The productivity loss for individuals incarcerated in prisons as a result of a conviction for a crime related to their severe mental disorders is also estimated as 50 percent. With commensurate coverage, the cost reduction is estimated to be \$0.1 billion.

Reduction in general medical care. Reduction in general medical care is expected to result as a cost offset of providing appropriate and adequate mental health treatments, thus reducing the amount of physical health care required. The calculation is based on empirical findings derived from a study by Strain et al. (1991) that reported a 10 percent reduction in general health care costs as a result of mental health treatment. The average health care expenditure per capita in the U.S. in 1990 was \$2,800. By multiplying this amount (\$2,800) by the 4.1 million people with severe mental disorders who are expected to receive treatment, and by the 10 percent cost offset, the resulting cost reduction in general medical care is estimated to be \$1.2 billion.

The tabulation of the total annual cost savings (including the savings in indirect costs) of commensurate coverage, using the above conservative assumptions, is as follows:

Reduction in mortality	=\$0.2 billion
Reduction in morbidity	= 6.8
Reduction in criminal justice system costs	= 0.2
Reduction in social welfare costs	= 0.2
Reduction in incarceration costs	= 0.1
Reduction in general medical costs	= 1.2
Total savings	=\$8.7 billion

APPENDIX C: CURRENT COVERAGE FOR MENTAL DISORDERS IN PUBLIC PROGRAMS

Overview

Historically, State mental hospitals, which were publicly financed and operated, dominated the care for people with severe mental illnesses. In the 1960s, Medicaid was introduced as the major public health assistance program to increase access to health care for the poor, including mentally disabled individuals residing in the community. The largest of other public health care programs covering other segments of the population is Medicare, a federally administered program for the elderly and for the disabled in the Social Security Disability Insurance (SSDI) program.

Employment-related private health insurance grew rapidly in the 1950s and the 1960s in the U.S. to cover the majority of the working population and their dependents. Coverage in these health insurance packages was restricted however, emphasizing inpatient care in acute general hospital settings and offering limited outpatient care. Thus, public programs have continued to play a significant role in funding care for people with severe mental disorders (Rupp 1991).

Medicare Coverage for Mental Health Services

Eligibility: Medicare covers all people aged 65 and over who are eligible for Social Security, have been receiving Social Security Disability Insurance (SSDI) payments for at least 2 years, or have end-stage renal disease (Lave and Goldman 1990).

Covered Mental Health Services: Medicare coverage includes hospital insurance (Part A) and medical insurance (Part B) (Sherman, 1992).

o **Hospital Insurance (Part A):** The coverage by Medicare hospital insurance for general hospitals is the same for physical and mental disorders: 90 days per benefit period. (A new benefit period begins once a beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days.) A beneficiary has an additional 60 "lifetime reserve days" that can be used only once. Freestanding public and private psychiatric hospitals have a lifetime limit of 190 days.

The structure of the benefits for hospital insurance is the same for both mental and physical disorders. It includes a deductible of \$652 per benefit period. Coinsurance is required for days 61 to 90 at \$163 per day (daily coinsurance calculated as 1/4 of the Part A deductible). Lifetime reserve days are calculated at \$326 per day (daily coinsurance calculated as 1/2 of the medical insurance deductible).

o **Medical Insurance (Part B):** Medical insurance includes payment for physician services, outpatient hospital services, durable medical equipment, and some other services. Services of physicians (and other professional providers including psychologists, clinical social workers, and certain other therapists who are employed by or supervised by a psychiatrist or psychologist) are covered in psychiatric and general hospitals and skilled nursing facilities. They are also covered in the following outpatient settings: private offices; community mental health centers; comprehensive outpatient rehabilitation facilities; rural health clinics; health maintenance organizations; partial hospitalization psychiatric programs; and home health agencies. Outpatient prescriptions, including psychotropic drugs, are excluded from coverage.

Reimbursements: Under Part A, specialty psychiatric providers (all public and private freestanding psychiatric hospitals) are reimbursed under the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) rules, while the treatment of patients in scatterbeds of general hospitals is reimbursed under prospective payments system (PPS) rules. Most psychiatric units in general hospitals are reimbursed under TEFRA rules, but some are paid under PPS rules.

Under Part B, providers are paid "customary, usual, or prevailing fees" for treating both mental and physical disorders. For medical insurance there is a \$100 deductible per year, coinsurance, and a feature entitled "balancing bills" for fees above what Medicare will pay. A 20 percent coinsurance is required for inpatient services in hospitals and skilled nursing facilities, initial diagnostic evaluation, medical management of psychotropic drugs, treatment of Alzheimer's disease (except psychotherapy), and partial hospitalization psychiatric programs.

A 50 percent coinsurance is required for therapeutic outpatient services, follow-up diagnostic services, and all other outpatient mental health services. About three percent of the Medicare dollar is spent on mental health (Lave and Goldman 1990).

Medicaid Coverage for Mental Disorders

Eligibility: Medicaid is a joint Federal-State program that pays medical bills for low-income persons. These recipients become eligible for Medicaid mainly because they receive Federal income assistance through two programs: Aid to Families with Dependent Children; and Supplemental Security Income (SSI) for the blind, aged, and disabled, including those disabled by mental disorders. It may be the most important legal entitlement program for low-income people with mental disorders for both their mental health and medical care (Koyanagi 1988).

Covered Mental Health Services: The law does not establish a consistent, national program of services offered by Medicaid. Instead, it requires that each State offer nine specified services, then allows States the option of offering additional services. Through Medicaid all States provide:

- o Inpatient hospital services other than services in an institution for mental diseases (IMD);
- o Outpatient hospital services;
- o Physician and dentist services;
- o Laboratory and X-ray services;
- o Skilled nursing facility care for those over 21 other than care in an IMD;
- o Early and periodic screening, diagnosis, and treatment services for those under 21;
- o Family planning services and supplies;
- o Rural health clinic services;
- o Nurse-midwife services.

As of 1988, each State has the option of offering any of the following 12 services through Medicaid:

- o Medical or remedial care recognized under State law and furnished by licensed practitioners;
- o Home health services, which may include some mental health services;
- o Dental services;
- o Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders;
- o Prescribed drugs, dentures, prosthetic devices, and eyeglasses;
- o Diagnostic, screening, preventive, and rehabilitative services;
- o Inpatient hospital, skilled nursing facility, and intermediate care facility services for individuals age 65 or older in an IMD;
- o Intermediate care facility services for mentally retarded individuals or those with related conditions;
- o Inpatient psychiatric hospital services for individuals under age 21;
- o Case management, personal health, and respite care services;
- o Any other medical or remedial care recognized under State law and specified by the Secretary of Health and Human Services (DHHS);
- o Clinic services in a facility not part of a hospital.

Each State determines the exact program of Medicaid benefits it will offer, within broad Federal guidelines. Limitations in the Medicaid program for people with mental disorders include such restrictions as requiring Medicaid coverage of psychiatric hospital care only for those younger than 22 and older than 65 years.

Medicaid does not discriminate coverage or restrict services on the basis of diagnosis. However, limitations imposed by the States on the amount, duration, and scope of services each will cover effectively restrict access to services needed by people with severe mental disorders. Furthermore, because Medicaid covers limited outpatient care, a "perverse incentive" is created for using inpatient rather than outpatient services as the "usual" source of care (Taube 1990).

Reimbursement: Payments for covered services are made directly to the service provider for the covered individual. To participate in the Medicaid program, a provider must agree to accept Medicaid reimbursement as payment in full, although some States require copayments under certain circumstances. Because State Medicaid plans vary widely in who they cover and what services they reimburse, the amount spent also varies widely among the States. Medicaid per capita spending in 1984 ranged from \$382 in New York to \$52 in Wyoming. Nationally, the average per capita Medicaid spending in that year was \$148. Crude estimates suggest that about 15 percent of Medicaid dollars are spent on people with mental disorders, primarily for skilled nursing facilities, State psychiatric hospital care, and general hospital psychiatric care. The remainder is spent on community-based care (Taube et al. 1990).

State Mental Health Authority Programs for People with Severe Mental Disorders

Eligibility: Approximately 1.5 million adults aged 18 to 64 defined as having a "persistent and severe" mental disorder are considered to be the priority population by State mental health programs. While definitions of "persistent and severe" mental disorders vary from State to State, they are generally characterized by a diagnosis of schizophrenia, psychosis, major affective disorder, anxiety, or phobia and a resulting disability of such magnitude that self-care is not possible (Center for Vulnerable Populations 1992).

Mental Health Services: Services provided or funded by State Mental Health Authorities are categorized as residential services, community-based services, and specialized services. Because State programming and eligibility criteria vary, not all of the following services are available to all people, in all communities, or in all States. (Furthermore, not all the services are available to, or necessarily appropriate for, people with severe mental disorders.)

The residential services provided by States include the following types:

- o publicly operated institutions;
- o nursing home care;
- o group homes;
- o assisted living programs;
- o adult foster care;
- o congregate living programs;
- o supervised apartment living;
- o supported living programs;
- o domiciliary care.

State-run or -supported community-based services include:

- o homemaker services;
- o personal care;
- o day habilitation programs;
- o transportation;
- o vocational training services;
- o supported employment;
- o attendant care;
- o case management;
- o home modifications;

- o adult day care;
- o nutritional programs;
- o information and referral;
- o companion programs;
- o recreational services;
- o financial management assistance;
- o community support services;
- o self-advocacy.

Specialized services may include:

- o medication monitoring;
- o skilled nursing care;
- o psychological/psychiatric services;
- o home health services;
- o family counseling and support;
- o communication devices;
- o adaptive devices;
- o pre-admission screening;
- o crisis management services;
- o early intervention programs;
- o behavior modification services;
- o therapies (e.g., speech, physical);
- o emergency response systems;
- o legal assistance;
- o special education.

Expenditures/Reimbursement: Public expenditures, controlled by the State Mental Health Authorities for mental health services, were approximately \$12.2 billion in 1990. States contributed 80 percent of these dollars, and the Federal Government, 15 percent. Local governments contributed two percent and all other sources, three percent. The average annual expenditure per State was \$234 million.

The programs supported by these expenditures included: State psychiatric hospitals (total \$7 billion; State average \$135 million); other hospitals (total \$100 million; State average \$2 million); community-based programs (total \$4.5 billion; State average \$88 million); prevention, research and training (total \$107.5 million; State average \$2.7 million); and the administration of the State Mental Health Authorities (total, \$336.7 million; State average \$6.6 million). State Mental Health Authority annual per capita spending on mental health programs ranged from \$268 in Delaware to \$17 in Iowa (Center for Vulnerable Populations 1992).

APPENDIX D: COMPARABLE MEDICAL ILLNESSES

While the total economic cost of mental illnesses seems large, it must be viewed in the context of the economic costs of other illnesses. The division of diseases into medical and mental types becomes more arbitrary with every new study of the physical causes of mental illness. There is good evidence for biochemical and structural etiologies for schizophrenia, affective disorders, anxiety disorders, and other mental illnesses, as well as behavioral risk factors for many physical disorders. Comparing some physical illnesses with mental illnesses may help to clarify the similarities.

About 50 percent of the U.S. noninstitutionalized population has a respiratory condition in any 1 year. This figure includes both acute and chronic respiratory conditions. About 15 percent of those with a respiratory condition seek ambulatory health care for their illness (National Center for Health Statistics 1986). Mental disorders are also classified as either acute or chronic and, like respiratory illnesses, most mental illnesses are acute. In any 1 year, about 25 percent of those with mental illness seek care within the health system. The total economic cost of respiratory diseases was estimated to be \$99 billion in 1990 (National Heart, Lung, and Blood Institute, unpublished).

Cardiovascular diseases include a broad spectrum of conditions that are in many respects similar to those included in mental illness: Both types of conditions tend to affect a large portion of the population and are usually treated with medications. Like mental disorders, cardiovascular diseases are rarely "cured" but usually can be controlled and have a variety of effects on patients ranging from the less severe to the life threatening.

In 1990 about 18 percent of the population had a cardiovascular disease while 22 percent had a mental illness. In contrast to the 25 percent of the mentally ill who seek care in the health system in 1 year, 60 to 80 per cent of those with cardiovascular diseases are seen by a physician in any one year (National Center for Health Statistics 1972). The direct and indirect costs of cardiovascular diseases were estimated to be \$160 billion in 1990 (National Heart, Lung, and Blood Institute, unpublished). In the same year, mental illnesses were estimated to have economic costs of \$148 billion (Rice and Leonard 1992). While there are differences in treatment modalities and the ways that illnesses are defined among these conditions, this places the cost of mental illnesses in a context that allows comparison with other medical conditions. Table I (below) compares the costs of mental illness, cardiovascular disease, and respiratory disease for 1990.

Table I

The Costs of Respiratory Disease, Cardiovascular Disease, and Mental Illness: 1990 (in billions of dollars)

	Respiratory Diseases	Cardiovascular Diseases	Mental Illnesses
Direct Costs	\$57	\$85	\$67
Indirect Costs	42	75	75
Other Related Costs	0	0	6
	-----	-----	-----
Total Cost	\$99	\$160	\$148

The direct costs of an illness represent the resources needed to treat the person affected by the illness. They include hospitalization costs, payments to physicians and other health care personnel, the costs of medications, and other costs. Indirect costs are the costs imposed on society because of the missed productivity of those who are ill or die prematurely. For mental illness, there are also other costs, mainly related to the criminal justice system and family caregiving, that are not relevant for other types of illnesses. The direct costs of cardiovascular and respiratory diseases comprise more than one-half of the total cost of these illnesses (53 percent and 57 percent, respectively), while the direct costs of mental illness comprise less than one-half of the total cost of this disease (47 percent).

To display better the similarity of mental illness to medical illness, it is useful to examine one particular disease in each classification. Severe diabetes and schizophrenia share many characteristics. Severe diabetes affects about one-third of the 6.2 million Americans with diabetes (defining "severe" as an illness that has required hospitalization). Thus 2.5 percent of the population have diabetes, and about 0.83 percent (2.0 million) have severe diabetes (National Center for Health Statistics 1988, 1991).

Of the U.S. population aged 18 to 64, about 2.5 million currently experience schizophrenia (Rice and Miller 1992). Both severe diabetes and schizophrenia can involve a loss of some of the abilities to support and care for oneself. Most treatments for these illnesses are with medications or counseling.

The Economic Impact of Diabetes

Diabetes is a chronic condition that causes significant disability among those it affects. Not only does the disease impose significant costs for the care of patients, it also imposes costs on our society from the loss of the productivity of those who have diabetes. Good, current cost data for all types of diabetes do not exist, but a recent study examined the economic impact of non-insulin-dependent (Type II) diabetes (Huse et al. 1989). Since about 93 per cent of all people with diabetes have Type II (non-insulin-dependent) diabetes, this study provides a substantial guide to the cost of diabetic illness. The other types of diabetes include insulin-dependent (or Type I) diabetes, gestational diabetes, and other, more rare types that are caused by chemical exposure or pancreatic disease. All cost data for the Type II diabetes group have been used to represent the costs of the other types of diabetes because data are not available for the latter.

To employ data from this study, certain assumptions about the costs of severe diabetes are necessary: It is assumed that all hospital costs, all nursing home costs, all disability costs, and all mortality costs incurred as a result of diabetes are due to severe diabetic illness. Because diabetes leads to other medical conditions such as circulatory disorders, visual disorders, neuropathies, nephropathies, and skin ulcers, the costs of these related medical conditions must be taken into account. The other costs attributable to diabetes were apportioned to the severe group according to their part of the entire diabetic population (33 percent). Table II (below) summarizes the estimates of the economic impact of all diabetics and those severely affected by the disease in 1990.

Table II
COST OF DIABETES 1990
(in billions of dollars)
(Huse et al. 1989)

	All Diabetics	Severe Diabetics
Direct Costs	\$17	\$15
Hospitalization Costs	4	4
Nursing Home Costs	3	3
Related Medical Conditions Costs	7	7
Other Costs	3	1
Indirect Costs	10	10
Disability Costs	3	3
Mortality Costs	7	7
Totals	<hr/> \$27	<hr/> \$25

Almost 92 percent of the entire cost of diabetes can be attributed the 2.0 million Americans with severe diabetic disease.

The Economic Impact of Schizophrenia

Schizophrenia is a chronic mental illness characterized by disordered thinking, hallucinations, delusions, and impaired functioning. Like diabetes, schizophrenia imposes costs on our society for direct treatment and for reduced or lost productivity. In 1992 Dorothy P. Rice and Leonard Miller estimated the economic cost of schizophrenia as \$32.54 billion in 1990 (Rice and Miller 1992). The method used to make this estimate is similar to that used to estimate the costs of severe diabetes in that it includes direct costs of patient care and indirect costs of morbidity and mortality.

Other costs are associated with schizophrenia that are not usually associated with severe diabetes. Many people with schizophrenia are unable to care for themselves since they are not in touch with reality. Because their judgment is markedly impaired, some individuals may be involved in crimes and may be incarcerated. Rice and Miller include the related costs of this illness, such as social welfare administration, criminal justice administration, and family care giving. Table III (below) summarizes the economic costs of schizophrenia.

TABLE III
The Economic Costs of Schizophrenia
(1990 Estimates)
(Rice and Miller 1992)

	Billions of Dollars
Direct Costs	\$18
Direct Patient Care Costs	17
Direct Related Costs	1
Indirect Costs	15
Morbidity	11
Mortality	1
Other Indirect Costs	3
Total Costs	<hr/> \$33

Although the estimates for the total costs of schizophrenia exceed those for severe diabetes by about \$7 billion, the per capita costs estimates are much closer. For each of the 2.5 million individuals with schizophrenia, the total economic cost is about \$13,000, while the total economic cost for each person with severe diabetes is \$12,632.

Also of importance is the difference in direct and indirect costs between the two diseases. Direct costs reflect the outlays needed to treat patients affected by these illnesses. Indirect costs are the costs to society because these people are unable to work or die prematurely due to their disease. In 1990 the direct costs made up about 61 percent of the total costs of severe diabetes. For schizophrenia, direct costs made up 55 percent of the total cost of the disease. The total direct cost for treating each person with schizophrenia is \$7,158, while the direct cost of treating each person with severe diabetes is \$7,725. This means that per patient, severe diabetes imposes more costs for treatment than does schizophrenia. It also means

that the potential gains -- in terms of reducing morbidity and mortality costs through treatment -- are greater for schizophrenia.

Conclusion

Both severe diabetes and schizophrenia are chronic illnesses that impose significant costs on our society. While cost estimation techniques differ and certainly contain some errors, the estimated total economic cost of schizophrenia is within \$500 per patient of the cost of severe diabetes. In addition, the per capita direct costs of treating schizophrenia is less than that of treating severe diabetes. This analysis provides a reasonable context for evaluating the economic impact of this severe mental illness.

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STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION

**HEALTH CARE REFORM:
IMPLICATIONS FOR INCLUSION OF MENTAL HEALTH SERVICES****INTRODUCTION**

The National Mental Health Association (NMHA) appreciates the opportunity to submit testimony before the Senate Labor and Human Resources Committee. The NMHA is the nation's oldest and largest voluntary charitable organization working to change the way America thinks about mental illness and mental health. Through 400 affiliates in 43 states and the District of Columbia, NMHA works to change attitudes toward mental illnesses, to improve services for people who suffer from them, to promote mental health and, ultimately, to prevent mental illness. Mr. Chairman, we would like to commend you and your colleagues on the committee for holding this hearing today. Persons with mental health care needs have, historically, been left in the margins in public policy deliberations. Your staunch commitment to those persons who suffer from a mental illness is, again, evidenced today by bringing the key mental health issues to the table. For that, Mr. Chairman, NMHA is grateful. Today, we would like to examine the Clinton Administration's bill to reform the health care system from a mental health perspective. We hope to draw attention towards those provisions which will ultimately benefit persons who suffer from mental illnesses, as well as challenge those provisions which discriminate against them.

THE PRESIDENT'S BILL: WHERE THE BENEFIT SUCCEEDS**Insurance Reforms**

Mr. Chairman, the NMHA is quite enthusiastic regarding the general direction of President Clinton's Health Security Act, which is designed to dramatically overhaul the health care financing and delivery system. A health care system that costs just

under one trillion dollars to administer yet fails to offer insurance coverage for unprecedented numbers of citizens is in dire need of reform. We believe that the first way to begin the process is to give the American people a sound sense of security. The issue of security is central to President Clinton's bill. Extending coverage to all Americans is a fundamental tenet which NMHA has traditionally promoted. There are many low-income persons in the United States, including those who are homeless, who suffer from mental illnesses. Many of these people, hence, cannot afford the high price tag often associated with health care insurance policies. If the premiums happen to be nearly affordable, however, the coverage is seldom adequate. Consequently, persons with mental health care needs often go without clinically necessary care. This pattern will be curbed, however, under the President's plan. All Americans will be afforded access to a broad array of health care services, regardless of their ability to pay.

Tantamount to the issue of security is the package of insurance reforms which the President has proposed. For decades, the insurance industry has discriminated against persons with mental illness through a series of pernicious practices. Far too often, in today's health care system, persons with mental illness are denied coverage to basic care. Insurance companies use a process called "medical underwriting" which attempts to assess risk and, ultimately, approve coverage only for those applicants who have an unblemished medical history. Last week, we heard a story from a Vietnam Veteran who, many years ago, sought help from a therapist for what was later diagnosed as Post-Traumatic Stress Disorder. He was unable to work and his level of functioning was considerably diminished. After intensive therapy, he was able to return to work and function quite well at home and in the community. However, just recently, he was denied health care coverage because he was considered "too much of a risk." Under the President's plan, this discriminatory practice will be prohibited. Insurance companies will no longer be

able to deny coverage to anyone on the basis of a pre-existing condition. The plan replaces experience rating (charging premiums based on certain factors such as health status) with community rating, whereby no individual in a city or region could be charged more than others in the same geographic area based on health status, age, race, employment, health history, or other factors.

The Provision of Needed Services

In the President's bill, the myriad needs of traditionally vulnerable populations have finally been confronted. The NMHA praises the work of Mrs. Clinton's Health Care Reform Task Force for including mental health services in the standard benefit package which all accountable health plans must, at a minimum, offer to all their enrollees. Additionally, we would be remiss in not acknowledging the leadership of a past member of the NMHA Board of Directors, Tipper Gore. For many years, she has advocated for improved services for persons with mental illness and has made mental health care reform her number one priority. Mrs. Gore tirelessly argued the urgency of inclusion, as well as enhancing the package of mental health services.

For the first time in history, Mr. Chairman, all Americans will be entitled to a package of mental health services. The president's bill requires all accountable health plans to offer inpatient hospitalization and outpatient psychotherapy visits. We are also quite pleased with those provisions in the bill which lift all lifetime limits on mental health services. Most insurance companies have traditionally set restrictive limits on the amount of services a person with mental illness can access during the course of a lifetime. In this arrangement, persons with severe mental illnesses can quickly exhaust their benefits early in life. In the past, persons who have reached their lifetime limits -- but still required treatment -- were dumped into

the public mental health system at increased costs to taxpayers. Now, with the elimination of these lifetime limits, the process through which the two-tiered mental health system (public and private) is integrated, will be more permissive.

THE PRESIDENT'S BILL: WHERE BENEFITS CAN BE IMPROVED

Continuation of Restrictive Limits

Mr. Chairman, the NMHA has historically advocated for a comprehensive and flexible mental health benefit in health care reform. If the goal of national health care reform is true reform, than conventional ways of doing business must be adjusted. We bring this to your attention because we believe current data support non-discriminatory benefits for treatment of mental disorders. Restrictive limits -- as in the administration's bill -- on the amount, duration, and scope of care are -- for the most part -- not in place for people with physical illness and should not, by any means, be in place for people with mental illness. The President proposes annual limits on the number of inpatient days (60), outpatient psychotherapy visits (30), and community-based service days (120) to which a person with mental illness is entitled in a given year. This approach fails to account for the colossal breakthroughs in mental health service delivery throughout the past decade.

Mr. Chairman, you know as well as we that mental illnesses are equally as debilitating as physical illnesses. In fact, the treatments of mental illness can even be more efficacious. A recent study by the National Institute of Mental Health revealed that the success rate for treating bipolar disorder -- otherwise known as manic-depression -- is 80% where the success rate for treating heart disease is 41%. Nevertheless, hospital days are not limited to a patient with heart disease or any other physical illness. We view this as discrimination and keeping the stigma of mental disorders very much alive. We would urge you and your colleagues to act immediately in removing these highly restrictive limits. We understand that the bill

recommends a phasing-in of the mental health benefit so, that by the year 2001, mental health will be at full parity with physical health. This means that coverage for the treatments of mental illnesses will be equitable to the coverage for the treatments of physical illnesses, with the various day and visit limits being completely lifted. However, mental health will have to wait until after the turn of the century to be on a level playing field with physical health.

Discriminatory Cost-Sharing Arrangements

Another section of the bill where we believe improvements could be made, Mr. Chairman, is the cost-sharing arrangements provision for outpatient psychotherapy. The president's bill recommends that outpatient psychotherapy visits come with a 50% copayment. However, outpatient hospital visits for physical ailments come with a 20% copayment. These cost-sharing arrangements clearly discriminate against persons with mental illness. Many persons suffering from severe mental illness require intensive outpatient therapy. It is often clinically necessary, during the course of treatment, for such people to enter into outpatient therapy several times a week. A 50% cost-sharing requirement, for each visit, is most excessive. The copayment required for an outpatient psychotherapy visit should not be greater than the copayment required for any other outpatient physician visit.

Discrimination Against Children with Mental/Emotional Disorders

Mr. Chairmen, another aspect of the bill where improvements could be made is how it addresses the mental health needs of children and youth. The bill recommends the same benefit package for all persons with mental health care needs. This approach fails to recognize that children presenting with these disorders must be afforded access to an enriched package of mental health services. In a number of categories in the bill, the unique needs of children are addressed.

Eyeglasses are covered only for children. Basic dental services are covered only for children. Maternal and child health services (for pregnant women and children of low-income families) are enriched. Only in the mental health benefit are children treated like "little adults." Mr. Chairman, last year you sponsored legislation calling for the development of community-based systems of care for children with serious emotional disturbance. In fact, you have been the leader of a national effort to encourage state government and county agencies to address the special and distinct mental health needs of children. NMHA strongly believes that -- at a minimum -- full parity of coverage should first be provided to children and adolescents immediately upon implementation of President Clinton's health care reform legislation in 1997. This policy represents a wise investment that could be attained without skyrocketing costs.

Elimination of Community-Based Services/Case Management

Mr. Chairman, our last point of suggestion for an improved mental health benefit involves the provision of community-based services. The draft summary of the president's plan released in early September contained secure financing and coverage for a comprehensive package of community-based mental health services which are crucial for keeping children with serious emotional disturbances and adults with mental illness with their families and out of institutions. Individuals were covered for 120 days of partial hospitalization, psychiatric rehabilitation, intensive home-based services, day treatment, and behavioral aides for children. This package of services is a critical component of a comprehensive mental health benefit. It provides services along the continuum and is a significant ingredient of a sound system of care. However, there is now confusion about this component of the mental health benefit because the president's detailed bill released on October 27 makes these services optional. In other words, accountable health plans can

offer these community-based services at their discretion. The same holds true with case management. The availability of case management services are particularly crucial for children with serious emotional disturbance in foster care, juvenile justice, and special education systems as well as adults with serious mental illness - because of the multiple needs these two high-risk populations have. In the earlier White House draft, case management services appeared to be mandatory and could be offered on a flexible basis. The detailed bill makes case management services optional. Without case management, Mr. Chairman, it would be impossible to coordinate the delivery of services to those populations most in need.

According to Clinton Administration officials, there is a drafting error in the bill and the package of community-based services and case management would indeed be mandatory for health plans to offer. Mr. Chairman, we urge you clarify this situation. If there is indeed a drafting error, we would ask that you take immediate action to make the necessary amendments.

CONCLUSION

Mr. Chairman, the time is now to bring about change in the way mental health and mental illness is viewed in society, in the workplace, at home, in the schools, and most significantly -- in public policy. Until policy dictates the end of discrimination, the stigma of mental illness will be kept alive. As long as stigma is kept alive, persons in need of clinically appropriate care will go without it, at additional costs to taxpayers. Mr. Chairman, we applaud the efforts of health care reform because it is the right thing to do. However, health care reform without a comprehensive and flexible mental health benefit is no reform at all. Our nation cannot afford to continue with the customary approach with respect to the delivery of mental health services. We cannot afford to neglect the major breakthroughs of many Fortune 500 companies (such as McDonnell Douglas, Honeywell, and Digital). By providing

an open-ended system of mental health care for their employees, billions of dollars are being saved. We know what works and what does not. We need to adopt those concepts of service delivery that work, and jettison those that have failed. Only then can we truly proclaim this comprehensive initiative as "reform." The NMHA pledges to work with you and the Committee in the months ahead to help define the most appropriate package of mental health services.

Thank you once again for the opportunity to submit testimony. Working together, we can ensure that federal public policy ultimately ends the discrimination against persons with mental illnesses.

STATEMENT OF THE LEGAL ACTION CENTER

Thank you for the opportunity to submit testimony on the substance abuse benefit in the American Health Security Act. The Legal Action Center is a not-for-profit organization that specializes in the legal and policy issues related to drugs, alcohol and AIDS. We work on behalf of the individuals with these health problems and the many institutions that serve them. In addition, the Center staffs the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, a coalition of twenty state-based treatment and provider associations that serve primarily lower income individuals and those most at risk for serious drug and alcohol problems. A list of the members is attached.

The inclusion of drug and alcohol treatment in the standard benefit package in the American Health Security Act is a milestone in the nation's effort to combat one of our most serious public health problems. We applaud the Administration for recognizing that a health reform bill that does not cover treatment for drug and alcohol problems will neither control costs nor create healthy, secure families.

At the same time, we believe that the substance abuse benefit as currently structured does not meet several of the Administration's health care reform principles. (See Attachment A for a description of the benefit.) The proposed benefit does not guarantee a uniform set of drug and alcohol treatment services across all health plans, and it does not simplify the

delivery of these services for consumers or health professionals. In addition, we have grave concerns that the benefit will not expand services to individuals with the most serious drug and alcohol problems, the so-called "hard-core users," whom the Administration promised in its Interim Drug Strategy to reach through health care reform.¹ The benefit's length of stay limitations, cost sharing requirements and utilization review standards may dramatically limit access to services and leave the most seriously ill individuals worse off. We have included recommendations at the end of our testimony that would address these concerns.

Congress must include coverage for a comprehensive range of substance abuse services in the final health care reform legislation. Providing such comprehensive coverage would cost approximately \$45 per person.² Failure to do so will cost tens of thousands of lives and literally billions of dollars in health costs related to HIV/AIDS, tuberculosis, fetal alcohol syndrome and other conditions related to infant exposure to drugs, cirrhosis, emergency room admissions, accidents and other medical conditions resulting from untreated alcoholism and drug dependence. It will also contribute to violence, child abuse and other crimes, homelessness and destruction of families that plague our Nation.

A. The Need for A Drug and Alcohol Treatment Benefit

We are delighted that the Administration has included drug and alcohol treatment in its standard benefit package and has taken the significant step of removing all lifetime caps on treatment. The plan also recognizes the critical importance of integrating the current drug and alcohol treatment system into the mainstream health care system, while retaining the unique components of the treatment system that have delivered appropriate, cost effective care to hundreds of thousands of individuals and families. Specifically, it recognizes the need to retain community based treatment and to ensure that services are provided by only those entities legally authorized to do so and in the most cost-effective setting.

The decision to include drug and alcohol treatment in the standard benefit package is not only humane but also a cost saver. While some have urged the Administration and Congress to eliminate substance abuse coverage from the benefit to reduce costs, the simple truth is that eliminating this benefit would dramatically increase our Nation's health and social costs.

A recent study estimated the total cost of drug and alcohol abuse in 1990 alone to be \$166 billion, \$99 billion of which was attributed to alcohol abuse and \$67 billion to drug abuse.³ Numerous other statistics reveal the tremendous health costs that are directly linked to untreated drug and alcohol problems. Providing treatment would eliminate or dramatically reduce these costs.

- Over 32% of AIDS cases are linked to injecting drug use and 70% of all pediatric AIDS cases are linked to maternal exposure to HIV through drug use or sex with a drug user.⁴ The medical cost for treating persons with HIV/AIDS ranges from \$85,000 to \$150,000 per patient.⁵
- Between 25% and 40% of all general hospital patients are there for alcoholism-related complications.⁶ Hospital care typically costs between \$400 and \$600 per day.
- The total annual cost of care of children born with fetal alcohol syndrome is \$1.6 billion (in 1985 dollars assuming an incidence rate of 1.9 children per 1,000 births), of which \$1.3 billion is for residential care and support services for mentally retarded persons over 21 years, \$118 million for neonatal intensive care services and \$118 million for full-time residential care for severely mentally retarded persons under 21 years.⁷
- A California study found that children who were diagnosed with substance abuse exposure problems had Medicaid expenditures almost twice the rate of Medicaid children not exposed in utero. Over 18% of the substance exposed children were born with low birth weight as compared to 7.7% of the nonexposed children.⁸
- The rate of alcohol-related hospitalizations among elderly individuals (65 years and older) is the same as the rate related to heart conditions. In 1989, hospital care for individuals with a primary alcohol diagnosis (38% of the cases) cost Medicare \$233.5 million.⁹

Untreated drug and alcohol problems also impose tremendous -- but avoidable -- costs on the foster care and criminal justice systems.

While the costs of not treating drug and alcohol problems are enormous, the costs of comprehensively treating these problems is miniscule. Lewin-VHI, Inc. has estimated the cost of a comprehensive substance abuse benefit to be approximately \$45.10 per covered life per year. Such a benefit would provide a full continuum of services, assume a 10% increase in utilization, a 50% increase in the funding per unit of service to improve the quality of care particularly in the publicly funded system, and provide lengths of stay similar to the longer lengths of stay currently provided in the publicly funded sector with an additional 10% increase in response to improve quality.¹⁰ The Legal Action Center has developed a comprehensive treatment benefit whose cost would fit in this range. (Attachment B).

Because treatment prevents so many costly health conditions, we cannot afford the failure to include a drug and alcohol benefit in health care reform. Congress must ensure that the final health care legislation includes adequate coverage for substance abuse treatment and prevention.

B. The Need for a Stronger Substance Abuse Benefit

While the inclusion of a substance abuse benefit is a critical first step, we are very concerned that, as currently structured, the benefit will not achieve the enormous savings that it could. There are several reasons for this.

1. Lack of Adequate Coverage for Individuals Who Need Longer Term Care

The benefit does not provide coverage for the "hard-core" drug and alcohol dependent individuals who need longer term care. The Administration's drug strategy vows to expand treatment to these individuals whose untreated problems impose the greatest costs. But the benefit, which would require only limited residential and outpatient substance abuse counseling, is an acute care model that does not address their needs.

Many individuals, including criminal offenders, pregnant addicted women, women with children, the homeless, adolescents, the elderly and people with chronic drug and alcohol problems, need longer term residential habilitation services ranging from six months to eighteen months, as is currently provided with federal, state and local funds. The Administration's proposed benefit may be appropriate for most individuals who are employed, have a fairly stable family or support system and whose substance abuse problem was diagnosed at an early stage and, thus, only need rehabilitation.¹¹ But it is not adequate for individuals with the most serious and chronic problems.

In addition, the Administration's benefit would make two levels of care that hold out the greatest promise for chronically ill individuals -- intensive nonresidential treatment and case management -- totally discretionary.¹² This feature does not meet the Administration's principle of providing a uniform benefit package across all plans. It will also enable health plans to continue risk selection because plans could avoid individuals who are high risk for a wide range of diseases, including HIV/AIDS, tuberculosis, cardiopulmonary illness, by simply not offering these levels of care.

Finally, eliminating these levels of care will undermine the ability of the health care system to provide a continuum of necessary services that individuals with chronic problems need. In the short run, the lack of these services will promote continued dumping of sicker individuals into the publicly funded system, if public funding to treat them still exists. In the longer run, it will be more difficult to integrate the publicly funded treatment system into the health alliances.

While the Administration has stated that the publicly funded system will remain in place to provide care that is not covered under the benefit package, we have grave concerns about whether sufficient federal, state and local funds will in fact be available.

First, the Administration has estimated that 65 % of the treatment dollars available through the Substance Abuse Block Grant and federal categorical grant programs will be offset by the Act's substance abuse benefit. This figure, which was based on the Administration's September 7th proposal that was more comprehensive, is in our view totally off the mark whether based on the earlier or the current proposal. When several of the National Coalition member associations assessed the portion of services that would be offset by the comprehensive benefit, they estimated that no more than 30 % would be covered. That figure is certainly reduced under the current proposal.

Second, State and local funding now accounts for approximately 45 % of drug and alcohol treatment services nationwide, and states are currently required to maintain their level of funding as a condition of receiving federal block grant funds. State and local governments and charitable organizations invest substantial funds in longer term care. Under the Administration's plan, states and localities would not be required to maintain their efforts. Given the state financial responsibility under the Administration's proposal, there is a great likelihood that funds currently spent on drug and alcohol treatment will be diverted to fund other health care and that essential drug and alcohol treatment services will not be funded.

Thus, existing services could be severely reduced for individuals with the most serious drug and alcohol problems as well as those who are "dumped" from the health alliances due to limited coverage or restrictive benefit management.

2. Limited Coverage Because of the Merged Substance Abuse and Mental Health Benefit.

The drug and alcohol benefit would be merged with the mental health benefit under the Administration's plan. This means that individuals who need both substance abuse and mental health services will have access to only one set of benefits.

As a result, individuals with both mental health and substance abuse problems and individuals with HIV disease who may need mental health counseling as well as drug and alcohol treatment could easily exhaust the benefit and be without care.¹³ Considering the various swapping provisions in the benefit¹⁴, individuals with both needs could whittle down the residential benefit very quickly and, as a general matter, have no way of really knowing what their benefits are or planning their total care. This clearly does not simplify the delivery of health services for either consumers or providers.

Apart from these very real practical problems, the merger of these services reveals a lack of understanding about the diseases. Addiction and mental illness are two distinct diseases that are treated by different professionals in different settings and require different therapeutic approaches. The substance abuse treatment system developed because the mental health system and the general health care system were not providing appropriate care to individuals with underlying drug and alcohol problems.

There is no other set of illnesses for which the care is merged as well as limited in this fashion. It is analogous to saying that a woman with heart disease and breast cancer who has been hospitalized for the heart condition cannot get hospital care in the same year for breast cancer because she has exhausted her inpatient benefit. Or that a man with prostate cancer cannot receive inpatient treatment in the same year for injuries resulting from a car accident.

Moreover, the cost of these substance abuse and mental health services is dramatically different. Substance abuse treatment is much less expensive. The scope of substance abuse treatment seems to have been artificially and inappropriately capped, at least in part because of the cost of mental health services. This is borne out by a simple comparison of costs.

According to newspaper reports, the Administration is seeking a mental health/substance abuse benefit that would cost an average of \$240 to \$340 per person.¹⁵

One must assume that the proposed limited benefit fits that cost. Yet an analysis of the national expenditure for drug and alcohol treatment conducted by Lewin-VHI, Inc. estimates that current expenditures for substance abuse treatment in the public and private systems will amount to \$6.7 billion in 1993 or about \$25.75 per covered life. The current expenditure in the privately funded substance abuse system, which parallels the Administration's proposal more closely, is only \$13.55 per covered life.¹⁶ Clearly, the lion's share of the cost in the Administration's plan would be for mental health care.

As noted above, the cost of a comprehensive substance abuse benefit would be approximately \$45.10 per covered life. Thus, it is clear that far more comprehensive substance abuse services could be provided if the two services were separated and costed out independently.

3. Cost Sharing Requirements Will Be A Prohibitive Barrier to Many Individuals

The Administration's plan would require cost sharing for outpatient substance abuse counseling under all three arrangements (lower, higher and combination) and would impose specific deductibles and co-insurance for residential care and co-insurance for intensive nonresidential care (to the extent it is provided) under the higher cost sharing plan.

While the plan would provide some cost sharing reductions for low income families, under no circumstance would the co-payment requirement be reduced below the low cost sharing plan, unless a family qualified for AFDC or SSI. Thus, many poor individuals would have to pay \$10 for every outpatient substance abuse counseling session and \$25 for every family counseling session. Moreover, no outpatient counseling expenses or expenses for the second 60 days of intensive nonresidential care (to the extent it is provided) is counted toward the out-of-pocket limit. These are the only services in the Administration's plan for which the expenses are not counted toward the out-of-pocket limit.

These cost sharing requirements will be prohibitive for the vast majority of individuals who need to attend counseling sessions several times every week (and the many who could not afford even one visit) and, thus, will be a major barrier to obtaining necessary care and preventing relapse. The problem is only exacerbated by the fact that the co-payment requirement continues even if individuals and families incur catastrophic expenses.

The cost sharing requirements have been imposed generally as a way to control utilization. But the value of such controls has no applicability in the case of drug and alcohol treatment because the care is underutilized to begin with. Individuals with drug and alcohol problems often deny having a problem and look for reasons not to obtain care. Many have lost their jobs and personal resources before finally recognizing the need to enter treatment. For these reasons, co-payments will be a disincentive for most people with drug and alcohol problems and a huge barrier to their ability to receive the services they need.

4. Unregulated Utilization Review May Result in Inappropriate Care.

The Administration's plan would strictly manage the utilization of substance abuse services by placing critical decisions in the hands of a "health professional designated by the plan." This individual would determine whether an individual in residential care could get more than 30 days of care at one time, whether an individual could get more than 60 days of intensive nonresidential services (if this discretionary services is provided at all) and whether an individual whose first detoxification was unsuccessful could receive another chance at detoxification. The Administration's plan would not impose any standards on the health professional's qualifications, experience or knowledge of substance abuse issues and would not impose any standards for his or her utilization review protocols.

While it is clear that the Administration's plan will rely on utilization review to control costs and utilization of all services, the removal and transfer of important care decisions from the drug and alcohol treatment provider to the plan is different from the standards that would apply in other types of care. For example, with home health care, after each 60 days of services, the need for continued care is reevaluated by the person "primarily responsible for providing home health care," not a different person designated by the plan.¹⁷ Similarly, the person primarily responsible for providing outpatient rehabilitation services -- occupational therapy, physical therapy and speech pathology -- is also given the authority to decide whether services continue after each 60-day period.¹⁸

There is no reason to believe that one set of providers would make less appropriate care or more costly decisions than another set of providers, yet the Administration's plan assumes this to be the case. Indeed, practice has taught that unregulated utilization review decisions by individuals who fit the description of a "health professional" often leads to the

denial of necessary drug and alcohol treatment services and inappropriately restricted lengths of stay. If not properly performed, monitored and regulated by uniform standards, utilization review will lead to much greater costs. I have attached a set of principles developed by the Legal Action Center for the regulation of utilization review. (Attachment C)

C. Recommendations

To resolve the above concerns we recommend the following revisions.

1. Separate the substance abuse benefit from the mental health benefit and provide a comprehensive drug and alcohol benefit that addresses the needs of all individuals based on an individualized assessment of their problem.

2. To the extent a comprehensive substance abuse benefit is not included in the plan, retain the current funding level for the Substance Abuse Block Grant and other federal categorical grant programs and require States to maintain their investment in drug and alcohol treatment.

3. The outpatient substance abuse counseling benefit should be treated like a preventive clinic benefit with no cost-sharing requirements. In addition, the cost sharing for outpatient and intensive nonresidential services should be applied to the out-of-pocket limit.

4. Uniform utilization review criteria should be promulgated and the application of these criteria by plans should be closely monitored. In addition, the same utilization review and managed care standards contained in the legislation for all health services should be applied to substance abuse services.

Thank you for considering our views. We look forward to working with you as Congress crafts its health care reform legislation.

¹ Office of National Drug Control Policy, Breaking the Cycle of Drug Abuse: 1993 Interim National Drug Control Strategy, September 1993 at 6-9.

² See discussion infra on p. 4-5.

³ Institute for Health Policy, Brandeis University, Substance Abuse: The Nation's No. 1 Health Problem.

⁴ National Commission on Acquired Immune Deficiency Syndrome, "The Twin Epidemics of Substance Use and HIV," 1991.

⁵ U.S. Department of Health and Human Services, Surgeon General's Report to the American Public on HIV Infection and AIDS, 1993.

⁶ Substance Abuse: The Nation's No. 1 Health Problem.

⁷ D.P. Rice, et al., The Economic Costs of Alcohol and Drug Abuse and Mental Illness, 1990 at 153.

⁸ M.R. Ellwood, et al., "An Exploratory Analysis of the Medicaid Expenditures of Substance Exposed Children Under 2 Years of Age in California," September 1993.

⁹ W. L. Adams, et al., "Alcohol-Related Hospitalizations of Elderly People," Jr. of the American Medical Association, Vol. 270, No. 10 (Sept. 8 1993).

¹⁰ H.J. Harwood, et al., "Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches." (Discussion Draft developed under contract for the Legal Action Center, National Association of Addiction Treatment Providers, National Association of Alcohol and Drug Counselors, National Council on Alcohol and Drug Dependence and Therapeutic Communities of America).

¹¹ We also have concerns about how these individuals will fare under the Administration's benefit because of several unique features. First, the benefit would reduce the number of residential days available to an individual after he or she has received more than 30 outpatient substance abuse counseling visits on the basis of one residential day for every four outpatient visits. Second, utilization of the benefit will be strictly regulated by a "health professional designated by the plan," which under current practices has led to the denial of essential services and forced individuals to fail in an outpatient setting before being given residential care.

Putting these two features together, an individual could be required to attend outpatient services by the plan, reducing down the number of residential days available, and then have little residential care available upon failing in outpatient.

¹² These benefits were not optional in the September 7th version of the plan.

¹³ It is possible that there will be no publicly funded "safety-net" for individuals who need additional care, because the funds currently available under the Substance Abuse and Mental Health block grants and categorical grant programs will be eliminated to the extent a service is included in the standard benefit.

¹⁴ In addition to the swapping that would exist for outpatient substance abuse counseling and intensive nonresidential care (to the extent it is provided), individuals would also be permitted at the discretion of the plan to obtain more than 30 psychotherapy visits by reducing 1 day of residential care for every 4 psychotherapy visits.

¹⁵ The Wall Street Journal, November 5, 1993, B14. We are relying on newspaper coverage because the Administration has not yet disclosed the cost of the benefit.

¹⁶ H.J. Harwood, et al., "Healthcare Reform and Substance Abuse Treatment: The Cost of Financing Under Alternative Approaches." (Discussion Draft)

¹⁷ Section 1118.

¹⁸ Section 1123.

Substance Abuse Benefit: Health Security Act

<u>Mandatory Services</u>	<u>Limitations*</u>	<u>Lower Cost Sharing</u>	<u>Higher Cost Sharing</u>
Screening and Assessment	None	No Copayment	No Coinsurance
Crisis Intervention	None	No Copayment	No Coinsurance
Detoxification	1 Episode ^b	No Copayment	No Coinsurance
Residential/Inpatient ^c	30 days/episode 60 day/year would be reduced if other services used ^d	No Copayment	1 day deductible 20% of applicable payment rate
Outpatient Substance Abuse Counseling and Relapse Prevention	30 group therapy visits if initially treated in residential or intensive nonresidential Additional visits if not initially treated in other care level ^e	\$10/visit ^f	20% of applicable payment rate ^f
Medical Management ^g (Brief office visits to monitor medications)	None	\$10/visit ^f	20% of applicable payment rate ^f
Collateral Services ^h (Family Services)	30 visits	\$25/visit until Jan. 1, 2001 and \$10/visit thereafter ^f	50% of applicable payment rate until Jan. 1, 2001 and 20% thereafter ^f
Outpatient Prescription Drugs	None	\$5/prescription	\$250 deductible 20% of applicable payment rate ^f

<u>Optional Services</u>	<u>Limitations</u>	<u>Lower Cost Sharing</u>	<u>Higher Cost Sharing</u>
Intensive Nonresidential	120 days/yr. ⁱ	No Copayment	20% of applicable payment rate
Case Management	Only provided individuals in outpatient care	No Copayment	No Coinsurance

- a. Day limits would be removed as of January 1, 2001.
- b. The only inpatient treatment allowed would be for medical detoxification from drugs or alcohol.
- c. The number of residential days would be reduced to the extent an individual was treated in an intensive nonresidential program (the first 60 days) or received more than 30 outpatient substance abuse counseling visits. Residential days would be reduced by 1 day for every 2 days of intensive nonresidential care and 1 day for every 4 outpatient visits.
- d. Additional outpatient detoxification would be provided only if a health professional designated by the plan determined that there is a "substantial chance of success."
- e. The plan is unclear as to whether these additional visits are only group therapy or also include individual therapy. These additional visits would reduce the availability of residential care by 1 day for every 4 visits.
- f. The copayment or coinsurance would not be counted to the out-of-pocket limit.
- g. This service would be applicable in a limited manner for individuals participating in methadone maintenance treatment programs. Individuals in such programs receive a range of counseling and health services in addition to the medication and monitoring services, which would not be covered by this level of care.
- h. Collateral services would be provided to family members if the drug or alcohol dependent individual is receiving treatment.
- i. The 120 day period would be divided into two 60 day periods. The first 60 days would be considered a substitution for residential care, and would reduce residential care by 1 day for every 2 days of intensive nonresidential. A second 60 day period would be provided if a health professional designated by the plan determines that additional treatment is "medically necessary or appropriate."

MODEL LEGISLATION MANDATING NATIONAL HEALTH INSURANCE BENEFIT FOR PREVENTION AND TREATMENT FOR ALCOHOLISM AND DRUG ADDICTION

I. SPECIFICATIONS OF PREVENTION AND TREATMENT FOR ALCOHOL AND DRUG ABUSE AND DEPENDENCE

Coverage for the prevention and treatment of alcohol and drug abuse and dependence shall be comprehensive and allow for services in the setting most appropriate for each individual. Individualized assessments should be based on clinical necessity and govern the intensity and duration of treatment.

The system of care must take into account that individuals entering treatment have diverse needs, some requiring prevention, some rehabilitation and others requiring more intensive habilitation efforts. While most individuals will not require all the services outlined in the model, the model should be flexible enough to accommodate individuals with diverse needs. In cases where the primary caretaker of children is residing in a program, drug and alcohol treatment services, including room and board where appropriate, will be provided for children.

At the minimum, benefits should allow for the following services, with appropriate applications of individualized services through case management:

1. prevention - clinical screening, health promotion and education on risks of drug and alcohol use;
2. intervention - including assessment, diagnosis, and referral;
3. detoxification - 10 days of treatment in a hospital, non-hospital, or ambulatory detoxification program as medically necessary in any calendar year, unless medical complications require additional days;
4. outpatient treatment - a full continuum of outpatient services should be provided including:
 - a. intensive day and evening treatment: 40 days in any calendar year;
 - b. outpatient - 60 visits in any calendar year;
 - c. continuing care - 60 visits in any calendar year;
 - d. family outpatient care, including preventive services for children irrespective of treatment status of parent: 60 visits in any calendar year;
5. residential treatment -
 - a. short-term: 30 days of treatment in a hospital or free-standing program in any calendar year;
 - b. long-term: up to 18 months of treatment in a residential program (halfway and quarterway houses, therapeutic communities);

6. case management - unlimited and determined as clinically appropriate; and
7. pharmacotherapeutic intervention - unlimited and determined as clinically appropriate.

II. Alcoholism and Drug Dependencies Prevention and Treatment Benefit Definitions *

1. Prevention - patient education about the risks associated with alcohol and drug use.
2. Intervention (including assessment, diagnosis and referral) - a structured review and evaluation of the individual's disease course, stage and prognosis including, when appropriate, consultations with family, employers and significant others to assist in the assessment, diagnosis and proper referral of the individual.
3. Detoxification - the medical and psychological management of an individual while he/she withdraws from alcohol and/or drugs.
4. Outpatient services - /
 - a. Intensive outpatient/day treatment - an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of treatment consisting of regularly scheduled sessions of a minimum of nine (9) treatment hours per week within a structured program. Services are tailored to meet the individual's needs, and include detoxification, medical management and psychological support.
 - b. Outpatient services - an organized non-residential service or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, treatment and recovery services to addicted patients. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.
 - c. Continuing care - a structured therapeutic involvement designed to enhance, facilitate, and promote the transition from primary care to ongoing recovery. The principle criterion for admission to continuing care is participation and satisfactory completion of a primary care treatment and intent to remain abstinent of alcohol and/or other nonmedical psychoactive substances.
 - d. Family outpatient services - an organized, non-residential services or an office practice with designated addiction treatment personnel or addiction-credentialed clinicians that provides professionally-directed evaluation, prevention, treatment and recovery services to the families of addicted individuals. Services are provided on a regular basis, usually fewer than nine (9) treatment hours per week.
5. Residential treatment -
 - a. short-term -- an organized service with designated addiction personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care, and treatment for addicted patients in a residential setting. Clinical services includes: medical; educational; and individual, group and family therapy.

* Some of these definitions were taken directly from the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, American Society of Addiction Medicine, March 1991.

b. long-term --

Halfway house care - an organized, long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual including educational and vocational rehabilitation and locating permanent housing.

Three-quarter-way house care - a semi-structured long-term (6-month) residential service with designated addiction treatment personnel or addiction-credentialed clinicians that provides ongoing support and supervision for individuals who are resuming activity in the community.

Therapeutic community - an organized long-term residential service (up to 18 months) with designated addiction treatment personnel or addiction-credentialed clinicians that provides a planned regimen of 24-hour professionally-directed evaluation, care and treatment of addicted individuals. Clinical services include medical; educational; and individual, group and family therapy. Therapeutic efforts are directed to the habilitation of the individual, including educational and vocational rehabilitation and locating permanent housing.

6. Case management - supervision and management of a patient's progress through the continuum of prevention and treatment services for alcoholism and drug dependencies' treatment, including assistance with gaining access to ancillary services such as health care, housing, education, job placement and training.
7. Pharmacotherapeutic intervention - an organized medical intervention with a patient under the supervision of a licensed physician that utilizes approved medications such as methadone or Antabuse in conjunction with comprehensive medical, casework and counseling services.

Principles for Regulating Utilization Review

1. A process for certifying or licensing the bodies conducting utilization review;
2. Provisions requiring the disclosure of the specific admission and treatment criteria used in determining the justification for any form of hospital, residential or outpatient services;
3. A description of an emergency preauthorization procedure that will include the process for allowing a smooth admission process for assessment and detoxification;
4. A description of the procedures the review agent will follow when making decision, including:
 1. policies and procedures to ensure that all applicable state and federal laws that protect the confidentiality of records are followed;
 2. a time frame within which decisions on admissions are made (we recommend that a decision be made within 24 hours of a request, and that a second opinion be obtained within 24 hours in the case of any adverse determination);
 3. procedures by which the review agent shall notify the insured and providers when payment for alcohol or drug treatment is denied or limited, including a written statement for the denial or limitation;

4. a provision that if a course of treatment has been preauthorized or approved for a patient, a private review agent shall not subsequently, including during any retrospective review, revise or modify the specific criteria or standards used for the utilization review for services delivered to that patient.
5. A description of an independent appeals process;
6. A provision requiring the disclosure of the names, addresses, telephone numbers, and qualifications of the personnel who will be performing utilization review for alcohol and drug treatment services, who shall be at least:
 1. a licensed practical nurse or licensed registered nurse with experience in the treatment field or health care professional with experience in the treatment field, for performing initial review;
 2. a licensed physician actively practicing or who has demonstrated expertise in the treatment field in initial denial determination prior to a final denial determination by the insurer.
7. Procedures to ensure that review agents will be readily accessible by telephone to the insured and providers at least 40 hours per week during normal business hours, and assurances that a toll-free telephone line will be provided for insureds, hospitals, and physicians to contact the review agent;
8. Procedures to ensure that the review agent will respond by telephone to insureds and/or providers within four business hours;
9. Procedures to ensure that no review agent shall enter a hospital or other treatment facility of a provider to interview an insured unless such activity has been approved in advance by such insured's attending physician or treatment counselor and such attending physician, counselor or designee shall be able to attend such activity which shall occur only during regular business hours.
10. A provision that no private review agent who will be performing utilization review shall enter into a contract or arrangement of any kind which provides that any compensation or benefit to be received by any such person is directly or indirectly, in whole or in part, affected by a determination of whether or not the insured's admission to or continued treatment is or is not medically necessary or appropriate.
11. A provision that a list be provided of third party payors for which the private review agent is performing utilization review;
12. Penalties for failure to comply with the law.

**National Coalition of State Alcohol and Drug Treatment
and Prevention Associations**

Alabama Alcohol and Drug Abuse Association

Arizona Association of Behavioral Health Programs

California Association of Alcoholic Recovery Homes

California Therapeutic Communities, Inc.

County Alcohol and Drug Program Administrators
Association of California

Florida Alcohol and Drug Abuse Association

Georgia Association for the Prevention and Treatment
of Substance Abuse

Illinois Alcoholism and Drug Dependence Association

Iowa Substance Abuse Program Directors' Association

Maine Association of Substance Abuse Programs

Massachusetts Alcoholism and Drug Abuse Association

Nevada Association of State Drug Abuse Programs

New Jersey Association for the Prevention and Treatment of Substance Abuse

New York State Association of Substance Abuse Programs

North Carolina Association of Alcohol and Drug Service Administrators

Association of Ohio Substance Abuse Programs

Drug and Alcohol Service Providers Organization of Pennsylvania

Drug and Alcohol Treatment Association of Rhode Island

Tennessee Alcohol & Drug Association

Wisconsin Association on Alcohol & Other Drug Abuse

THE AMERICAN PSYCHOANALYTIC ASSOCIATION

WRITTEN TESTIMONY BEFORE THE UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES November 8, 1993

The American Psychoanalytic Association is honored to have the opportunity to present testimony on the Health Security Act of 1993. We respect the monumental effort that has resulted in the act, its comprehensive scope, and the enormous job that lies ahead for the Congress as it fulfills its responsibility to work with the President in achieving health care reform.

The American Psychoanalytic Association is a regional society of the International Psychoanalytic Association, the worldwide organization serving the flourishing science and practice of psychoanalysis. We have over 3000 members and 32 accredited institutes and training centers across the country. The quality and scientific foundation of psychoanalytic training and practice have been the foremost concerns of the Association since its establishment in 1926. The training of a psychoanalyst requires from five to ten years of intensive work after the usual post-graduate professional education in psychiatry, psychology, or social work. Psychoanalysis is a highly specialized tertiary care treatment, like neurosurgery, for certain individuals with painful and disabling mental disorders for whom less intensive treatments will not be helpful. Much has been learned from psychoanalysis to inform the much more widely used variants of psychotherapy, whether short-term therapy, long-term supportive or maintenance treatment, or insight-oriented intensive psychotherapy. Each has to be selected according to the needs of the individual patient.

The Health Security Act represents the outcome of intensive study of the health care system. It deserves great respect and serious efforts to implement its fundamental principles. It would end major inequities and deficiencies in care by measures that implement universal coverage, a substantial basic benefit package, community rating, portability from job to job, and access to insurance regardless of health status.

Unfortunately, we have grave concerns about the structure of the plan as presented to the Congress. As we understand it, the immediate concern of this Committee is the economics of the new plan. In our view, the structure of managed competition appears to compound further the diversion of resources from patient care to administrative overhead, through complex, interlocking bureaucratic agencies. Furthermore, the plan's dependence for cost containment on profit-driven competitive entities compensated through capitation would seem to be a formula for further diverting money from patient care to entrepreneurial profits. Since the most cost-effective patient care is to treat a condition properly the first time, a system in which profits are derived by withholding care must inevitably be more costly to society in the long run because of inadequate pursuit of long-range, definitive treatment in order to enhance this year's bottom line.

The dangers of long-range costliness due to inappropriate care are especially significant in the case of mental illness. Mental illness including substance abuse affects a large part of the population and causes enormous suffering and disability, misdirected medical care, unemployment, homelessness, and crime. It contributes to three of the ten top leading causes of death: suicide, accidents (both killers of young people), and cirrhosis of the liver. Yet the Clinton plan entrusts the treatment of mental illness to competitive managed-care entities, which have already accumulated an appalling track record of giving minimal treatment of symptoms instead of definitive care. Mental health managed care companies are now bought and sold for sums in the hundreds of millions of dollars, all siphoned off from direct patient care into the equity of their owners. (Value Health, parent company of American PsychManagement, recently acquired Preferred Health Care for 425 million dollars.)

Except for a handful of enlightened managed care situations, the environment for effective, in-depth treatment of mental illness by intensive psychotherapy by highly trained professionals has been irreparably damaged by 1) threatened or actual disruptions of ongoing treatment relationships, 2) harassment by excessively frequent and intrusive reviews, 3) invasion of privacy, 4) substitution of minimally trained counselors for experienced mental health professionals, and 5) exclusion of patients from participation and responsibility for decisions affecting their own treatments. The provider system is fragmented beyond belief into competing provider groups, and patients often find crucial treatment relationships disrupted on a few weeks' notice as employers change from plan to plan. Yet data presented to the White House working group on mental health on the experience of Health Management Strategies in managing CHAMPUS mental health benefits has demonstrated that only minimal management, if any, of out-patient psychotherapy is necessary.

Psychoanalysts report the frequent experience of patients' coming to them for treatment for which they pay out of pocket, after being denied treatment or leaving managed care mental health services in discouragement because they knew they were not being helped. Essentially these patients have become an uninsured group. Patients want the opportunity to explore their unique problems in their own way, not to be crammed into a predetermined treatment agenda or treated with medications alone. A recent study showed that patients suffering from depression recovered less well in an HMO than in a fee-for-service setting¹. In subsequent testimony to the White House Health Care Task Force, these authors stressed the fact that the "sick poor" fared especially badly.

1. Rogers WH, Wells K, et al., Outcomes for adult out-patients with depression under prepaid or fee-for-service financing, *Archives of General Psychiatry* 50:517-525, July, 1993

More and more patients appear headed for situations of inadequate treatment of their mental illness. We are committed uncompromisingly to preserving the constitutionally guaranteed right of patient and doctor to contract privately and confidentially for clinically appropriate services without external interference in the conditions of treatment.

The 2001 A.D. deadline for full and comprehensive services to the mentally ill should be moved up to 1998 like the rest of basic services. The out-of-pocket costs and/or premiums for insurance coverage of any treatment short of what a fully non-discriminatory benefit would cover should be exempted from the restrictions on tax deductibility that have been proposed to discourage treatment outside the system.

The private office practice of psychoanalytical and psychotherapeutic treatments is one of the most cost-effective, low-overhead services in all of medicine. Practitioners work on an hour-for-hour basis and cannot make up for fee constrictions by increasing volume of patients per hour. Intensive psychotherapy is extremely inexpensive compared to hospital care. Yet, it involves an intense investment of personal interest and emotional resources on the part of the therapist; it calls on the therapist for deep self-knowledge and discipline. But the changes now happening under managed care threaten its very existence.

Psychoanalysis and intensive psychotherapy are the basic tools for the study of the doctor-patient relationship that is so important in all of medicine, especially in primary care. Lack of exposure to psychoanalytic psychotherapies in medical education would weaken the training of future primary care physicians.

The basic benefits package of the Clinton plan is highly unfavorable to effective psychotherapy. The prohibitive co-payment of 50% will put it out of the reach of most people with lower incomes; even half of a deeply discounted fee would be too much for many families. Even the "low-cost option" contains a punitive \$25 co-payment for psychotherapy. Contrasted with only a 20% co-payment for medication management, the high psychotherapy co-payment sharply encourages an already visible profit-building shift in practice patterns to having multiple short medication visits in an hour--often 4-5 in an hour in HMOs. This kind of assembly line is not what patients expect, and they don't like it. Studies demonstrate that in the treatment of depression, psychotherapy plus medication are more effective than either one alone; these patients are not getting the most efficacious available treatment.

The thirty-visit limit on psychotherapy coverage effectively denies the more seriously ill patient the opportunity to achieve substantive change. A majority of patients will complete treatment in thirty visits, but the remaining patients who need more include people with major depression, eating disorders, severe anxiety and panic disorders, obsessive-compulsive disorder, borderline personality disorder, and many psychiatric conditions affecting children and adolescents. These are not trivial illnesses.

Many of these people can be kept out of hospital and restored to productivity only by long-term psychotherapy. Furthermore, there is now an extensive literature on the benefits of psychotherapy in diminishing the costs and damage of general medical illness, even malignant melanoma. The effects of mental illness on bodily functions and the consequences of untreated personality disorders are closely related in many cases to the long-range effects of severe trauma and abuse, which can only be overcome by extended therapy. The attached report by Lazar, Hersh, and Hershberg summarizes this impressive literature, and we would be pleased to supply the committee with copies of the original studies.

The out-patient benefit in the Clinton plan is regressively poor insurance design. As a way of reducing hospitalization, out-patient treatment can be extremely effective. We are pleased that the White House has introduced the opportunity to trade in-patient days for out-patient visits, but we find the 4:1 ratio of tradeoff to be unrealistically low. Based on actual charges, a more realistic ratio would be 8 or 10 out-patient psychotherapy visits (CPT code 90844, 45-50 minutes) per traded-off hospital day.

Furthermore, providing more than thirty visits only when a patient is in imminent danger of hospitalization is like providing antibiotics for a pneumonia only when it would keep a patient off a respirator. Several diagnostic groups of patients recover substantially when they are assured one to two and a half years of stable, continuous treatment. Without this care they have medical, surgical, and psychiatric in-patient costs. The language in the current proposal would withhold planned definitive care; that is, extended care would be available only after a possibly preventable emergency occurred. It is a short-sighted and clinically inadequate benefit.

Regardless of the best medical efforts, some patients will require treatment in a hospital. For these people, medical diagnosis and intensive treatment in the hospital setting may be the only way to embark on a course to true recovery. Coverage for in-patient care is essential, and we do not advocate enhanced out-patient coverage at the cost of not having vital hospital services there when needed. Psychiatric hospitalization is almost invariably an emergency, so the discriminatory first-day deductible for psychiatric patients who are hospitalized is especially insulting and injurious, leaving the acutely ill psychiatric patient with an automatic \$1000-1500 debt for just passing through the hospital door. This too must be changed.

Why must the mentally ill wait till 2001 A.D. for equity and justice in access to treatment for their illnesses? That is two administrations and four Congresses away! Although the promise is hollow, the principle at least is enunciated in the Clinton plan: equity for the treatment of mental illness is the just, moral, clinically and scientifically correct, and economically advantageous thing to do. We hope that the Congress will have the courage to do it now.

We thank you for your attention to these concerns and for the opportunity to present them to you.

Norman A. Clemens, M.D.
Norman A. Clemens, M.D.

Arthur J. Farley, M.D.
Arthur J. Farley, M.D.

Co-chairs, Committee on Government Relations and Insurance

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THE AMERICAN PSYCHOANALYTIC ASSOCIATION

COMMITTEE ON
GOVERNMENT RELATIONS AND INSURANCE
NORMAN A. CLEMENS, M.D., CHAIRMAN
309 EAST 49TH STREET
NEW YORK, NEW YORK 10017

November 8, 1993

Senator Paul D. Wellstone
Hart Senate Office Building, Room 702
The United States Senate
Washington, D.C. 20510

Dear Senator Wellstone:

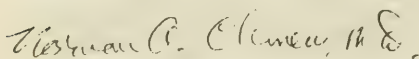
Enclosed is a slightly revised copy of the written testimony delivered to the hearing of the Senate Committee on Labor and Human Resources on November 8, 1993. There were two minor errors in the description of the American Psychoanalytic Association in the second paragraph, concerning the date of establishment and the number of institutes and training centers. These have now been corrected. I wrote the testimony while away from home at a meeting of the American Psychiatric Association, and I did not have my reference materials

for those two points of fact. The rest of the testimony remains unchanged. I would appreciate your substituting this statement for the original statement in the record, keeping the backup review of the literature as originally submitted.

Under separate cover I am sending you some additional material regarding intensive psychotherapy and psychoanalysis of children. I understand that Robert Gillman, M.D., on behalf of the Association for Child Psychoanalysis has also given material to Elliott Weiner.

On behalf of many, many colleagues and patients, I would like to express my appreciation for your powerful support of comprehensive, non-discriminatory coverage for the treatment of mental illness in health care reform. Your bill and Representative McDermott's deserve very serious consideration as the health care reform process unfolds, as they would avoid many of the problems described in this testimony. Thank you for your attention to these concerns.

Sincerely yours,



Norman A. Clemens, M.D.

Chair, Committee on Government Relations and Insurance

Cost of Mental Health Benefits in Employer-Provided Health Insurance

I am Edwin Hustead - actuary with Hay/Huggins Company and formerly chief actuary with the Office of Personnel Management. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

As the Chief Actuary for OPM, I was responsible for the review and analysis of all pricing and benefits design aspects of the Federal Employees Health Benefits Program (FEHBP). In my current position, I have continued to monitor and analyze that program as well as benefits programs of private sector employees. Our annual Hay/Huggins Benefits Report (HHBR) contains detailed information on the benefits and premiums of over 1,000 employer-provided health benefits programs.

In a quarter of a century of experience with employer-provided plans I have reviewed many studies on the coverage of mental health benefits. My experience is that insurers and sponsors often greatly overestimate the cost of mental health benefits based on anecdotal or erroneous information. When the errors are removed, all substantial data bases that I am familiar with show the same results - mental health benefits are a predictable and controllable cost item. For plans with better mental health coverage, the cost holds steady at 8 percent to 9 percent of the total premium. And that percentage is the same year after year. Certainly the cost of mental health benefits is rising - but at no greater rate than the cost of all health benefits.

I believe you have been provided with our most recent studies on mental health benefits. The following points are from those studies:

- The typical mental health provisions cover 30 to 60 days of inpatient care at 80 to 100 percent of the total bill. There is usually no coverage after the limit. This contrasts sharply with the typical provision for other inpatient care which covers 80 to 100 percent of the entire bill.
- The typical outpatient coverage is half of the bill up to a limit of \$1,000 to \$2,000 a year contrasted with 80 percent coverage of all other outpatient care.
- Mental health benefits in the average plan cost \$16 per single employee per month and \$42 per family. It would only cost \$3 per employee and \$6 per family to increase this coverage to the provide the same benefits as other care.
- Mental health benefits in the average plan cost 8.5 percent of the total premium.

Our analysis shows that our findings are consistent with those of other reports. One such report, a study of private sector plans by A. Foster Higgins and Company has been represented as showing rapid and "out of control" costs for mental health coverage. In fact, their report shows that mental health coverage consumes less than 9 percent of the total employer premium - a finding that is very close to ours.

Another prominent study is that of Salkever and Frank which shows that mental health claims are 12 percent of total health claims. This is very consistent with our findings on benefits since a lower part of the claim is paid by the plan. When adjusted to a paid benefits basis, the Salkever/Frank study also confirms that mental health benefits account for less than 9 percent of total health expenditures.

We have heard much about the supposed moral hazard of opening up mental health coverage without limits. The facts are that our studies and others show that the providers and patients already work to assure that benefits are primarily extended to those who are truly in need. Extensive analysis of FEHBP data during the 1970s, when there were no limits on in or out patient treatment, showed a very reasonable pattern of use and one that would not change the overall costs substantially. The FEHBP benefits included unlimited coverage of psychoanalysis.

Further, managed care of all covered treatment is at the heart of all of the proposals being considered today. Use of that approach should assure that benefits for all care, not just mental health, will be limited to reasonable and necessary treatment.

Statement by Edwin Husted
For Presentation on April 23, 1993
Prepared as of April 17, 1993

AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association (APA), a medical specialty society representing more than 38,000 psychiatric physicians in the United States is pleased to submit this statement to the Senate Labor and Human Resources Committee for the record of the Committee's November 8 hearing on mental health and substance abuse benefits in the President's health care reform plan.

The efforts of the Clinton Administration, and the continuing efforts of the Congress and particularly yourself and members of the Health Subcommittee, to reform the nation's health care system pose a unique opportunity for redressing discrimination against persons with mental illness (including substance abuse) and for ensuring -- once and for all -- that those who suffer from these illnesses have access to the care their illnesses require for effective treatment.

Sadly, discrimination against persons with mental illness is an ingrained aspect of American culture. It desensitizes the public to the reality that persons with mental illnesses are in fact suffering from illnesses, just like the millions of Americans who suffer from heart disease, cancer, or diabetes. By dehumanizing the victims and denigrating the illness, it also facilitates discrimination in health insurance coverage for persons with mental illness.

The APA's recommendations for health care reform are stated simply:

- *We urge your strong support for health reforms which end the pervasive pattern of discrimination against persons with mental illness and those who treat them.*
- *Coverage of treatment for mental illness should be included as a uniform health benefit in any health care reform proposal, subject only to the same scope and duration as are applied to non-psychiatric medical illness.*

- Persons with mental illness -- and their treating physicians and other health professionals -- should be subject to the same protocols, the same reviews, and the same cost controls as are required of patients with non-psychiatric medical illnesses and the physicians and other health professionals who treat them.

- We recommend consideration of the development of a prioritization process for all medical services, including mental health services, based on common criteria for outcome and usefulness to patients.

- Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, and home- and community-based services, as the patient's clinical needs require.

- In order to ensure that the clinical needs of patients with mental illness are properly addressed, care should be taken to ensure that there is a sufficient supply of psychiatrists, who

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- Patients should have access to a broad array of services offering a full continuum of care, including inpatient, outpatient, partial hospitalization, and home- and community-based services, as the patient's clinical needs require.

• In order to ensure that the clinical needs of patients with mental illness are properly addressed, care should be taken to ensure that there is a sufficient supply of psychiatrists, who are the only physicians specifically trained in the diagnosis and treatment of mental illness, and the only "mental health" providers who are physicians.

More than any other medical doctor, psychiatrists know first hand about the health insurance crisis affecting the United States. As the only physician specializing in the "primary care" of treatment for persons with mental illness, we are confronted every day by the fact that many of our patients effectively have no health insurance, particularly if they suffer from "severe" mental illness, for either their physical or mental treatment.

Our insured patients face discrimination in the form of higher coinsurance or different arbitrarily established limits on inpatient or outpatient coverage duration for their mental illness than is otherwise applied to other non-psychiatric medical illnesses. Many patients because of stigma refuse to use the insurance coverage they have out of fear of being denied health insurance if they ever change jobs.

Even the Federal Government is guilty of "discrimination by diagnosis." More than 30 years after the enactment of the Medicare program, our nation's senior citizens and disabled Medicare beneficiaries must still pay out of their own pockets 50 cents of every dollar for outpatient care by a physician psychiatrist, clinical psychologist, or clinical social worker. This is direct and blatant discrimination by the Federal Government against persons with mental illness. APA has worked for many years to end the 50 percent Medicare outpatient mental health coinsurance requirement, and we urge you to make this a reality as part of health care reform.

Discrimination against persons with mental illness is in stark contrast to the scope and prevalence of these illnesses. Mental illness (including substance abuse) affects tens of millions of Americans, knows no geographic boundary, respects no income distinctions, and is unaffected by race, sex, or religion.

- Some 40 million adults in the United States suffer annually from diagnosable mental disorders, including mental illness and alcohol and drug disorders.
- 11 million Americans suffer from "severe" mental illnesses such as schizophrenia, bipolar disorder (manic depression), or major depression.
- 12 million children suffer from some form of mental disorder.
- Maternal alcohol abuse is the leading preventable cause of mental retardation in children.
- One third of the nation's homeless persons suffer from severe mental disorders.
- One-fifth to one-quarter of persons with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all persons with AIDS will develop neuropsychiatric problems.
- Mental illness is a major problem among our nation's elders. At least 50% of elderly nursing residents have a diagnosis of a mental disorder such as major depression. The suicide rate for the elderly is twice that for the general population.
- Alzheimer's disease is the fourth leading cause of death among U.S. adults, afflicting an estimated 4 million elderly Americans who, along with persons with other dementias, occupy more than 50% of the nation's nursing facility beds.

- 30,000 Americans commit suicide each year. Suicide is the third leading cause of death for individuals between the ages of 15 and 24. Among adolescents, suicide has increased by 30 percent since 1950.

Mental illness is a serious health care problem in the United States. It should therefore be accorded a high priority in any health care reform plan. The Clinton health care plan -- as released in legislative language on October 27 1993 -- makes a commendable effort to end discrimination against persons with mental illness. Sadly, the Clinton plan will not provide non-discriminatory coverage from the outset in 1998, as 87% of Americans support according to the attached Parade survey. Perhaps the legislative process needs to catch up with constituents. The Administration has made it clear, however, that it plans to phase-in non-discriminatory coverage by 2001.

The general outline of the Administration's health care coverage for mental illness includes the following:

1998 Mental Health Benefit Coverage Limits (Clinton Plan, October 27 Legislative Language):

In general, the mental health and substance abuse provisions are as follows in 1998 (the first year the plan takes effect):

- Inpatient and Residential Mental Health and Substance Abuse Services: "Inpatient and Residential Services" are defined as those provided with respect to a diagnosable mental or substance abuse disorder to an inpatient of "a hospital, psychiatric hospital, residential treatment center, residential detoxification center, crisis residential program, or mental health residential treatment program, or a resident of a therapeutic family or group treatment home or community residential treatment and recovery center for substance abuse."

The maximum annual benefit is 60 days per year, with a 30 day per spell of illness limit. The 30 day limit may be waived if the patient is a danger to self or others.

Inpatient care may be used only (i) when less restrictive nonresidential or outpatient treatment would be ineffective or inappropriate, and (ii) when provided in the least restrictive setting that is effective and appropriate for the individual.

Inpatient treatment for substance abuse is covered "only for medical detoxification associated with withdrawal from alcohol or drugs."

- "Intensive Nonresidential Mental Health and Substance Abuse Treatment: "Intensive Nonresidential Treatment" is defined to include services provided in "a partial hospitalization program, a day treatment program, a psychiatric rehabilitation program, . . . an ambulatory detoxification program . . . home-based mental health services or behavioral aide mental health services."

A health plan "may (note not must) cover intensive nonresidential treatment at its discretion." Intensive nonresidential care may be used only when provided (i) to avert residential or inpatient treatment, (ii) to facilitate the earlier discharge of a patient from inpatient or residential care, (iii) to restore the functioning of an individual with a diagnosable mental disorder or substance abuse disorder, or (iv) to assist the patient in developing the skills and gain access to support services needed to achieve maximum level of functioning within the community.

Maximum coverage is 120 days per year. The first 60 days of care are required to be exchanged for inpatient care on a 2 for 1 ratio (i.e., the first 60 days of intensive nonresidential treatment depletes 30 days of available psychiatric hospital care). The remaining 60 days may be used only if it is determined that it is "medically necessary" by the health plan.

We are aware of reports that the White House intended to require health plans to offer intensive nonresidential treatment, and that the legislative language making this benefit an option was a drafting error. We are hopeful there will be revisions to the legislative language when the bill is introduced in Congress in the near future.

- Outpatient Treatment: "Outpatient Treatment" is defined to include screening and assessment, diagnosis, medical management, substance abuse counseling and relapse prevention, crisis services, somatic treatment services, psychotherapy, case management, and collateral services (i.e., services to family members when an individual is also receiving mental health or substance abuse treatment).

Coverage for psychotherapy and collateral services is limited to 30 visits per year. Additional visits "may (note not must) be covered at the discretion of the health plan" provided that the additional visits "prevent hospitalization or . . . facilitate earlier hospital release". These additional visits must be exchanged for inpatient and residential covered days on a 4 to 1 ratio (i.e., each 4 outpatient visits reduce available inpatient care by 1 day).

Substance abuse counseling is covered "only when provided by a substance abuse treatment provider who (i) is legally authorized to provide such services in the State in which the services are provided; and (ii) provides no items or services other than substance abuse counseling and relapse prevention, medical management, or laboratory and diagnostic tests for individuals with substance abuse disorders."

"At the discretion of the health plan" individuals receiving outpatient substance abuse treatment may have their inpatient and residential benefit "reduced by 1 day for each 4 outpatient visits."

By January 1, 2001, specified limits on mental health services would be eliminated, ensuring a fully flexible plan. Individuals would thus be entitled to whatever services they required in the setting most clinically appropriate for their treatment without having to factor in trade off days or other limits.

Cost sharing for mental health and substance abuse treatment is a function of the type of plan in which an individual is enrolled, and is thus very complicated to explain. In general, cost sharing rules are as follows:

- For "Low Cost" Plans: A catastrophic out-of-pocket stop loss of \$1,500 per individual and \$3,000 per family is imposed. No deductibles are charged. In general, there is no copayment for nonpsychiatric inpatient acute care services and a \$10 per visit charge for provider services (\$25 for some services, typically provided in an emergency room).

There is no deductible and no coinsurance for inpatient and intensive nonresidential mental health and substance abuse alternative services.

For outpatient mental health and substance abuse services other than psychotherapy, collateral services, and case management, there is a \$10 per visit charge.

For outpatient psychotherapy and collateral services provided prior to January 1, 2001, there is a \$25 per visit charge, reduced to \$10 per visit after that date.

For case management services there is no cost sharing.

Outpatient mental health and substance abuse services out-of-pocket expenses, as contrasted to those incurred for physical health care do not count toward the annual stop loss limits.

- For "High Cost" Plans: There is an annual deductible of \$200 per individual and \$400 per family. A catastrophic out-of-pocket stop loss of \$1,500 per individual and \$3,000 per family is imposed. In general, there is a 20% patient coinsurance for inpatient and outpatient services (with some exceptions).

For inpatient mental health and substance abuse treatment, there is a one day deductible and 20% coinsurance. Out of pocket expenses for inpatient mental health and substance abuse services count toward the annual deductible and stop loss.

For intensive nonresidential alternative services there is no deductible and a 20% coinsurance. Out of pocket expenses for the first 60 days of intensive nonresidential alternative mental health and substance abuse treatment count toward the annual stop loss, provided that they are drawn down against inpatient mental health and substance abuse treatment.

For outpatient mental health and substance abuse services other than psychotherapy, collateral services, and case management, there is a 20% patient coinsurance.

For outpatient psychotherapy and collateral services provided prior to January 1, 2001, there is a 50% per visit coinsurance, reduced to 20% per visit after that date.

For case management services there is no cost sharing.

- For "Combination Plans": There is an annual catastrophic out-of-pocket stop loss of \$1,500 per individual and \$3,000 per family. In general, cost sharing rules follow the "low cost" cost sharing for services received "inside the plan", and the "high cost" cost sharing for services received "outside the plan."
- "Mental or Substance Abuse Disorder" is defined as "a disorder that is listed in any authoritative text specifying diagnostic criteria for mental or substance abuse disorders that is identified by the National Health Board."

Impact of the President's Draft Plan

APA's response to the President's plan is very much on the order of "a glass half full." No other Administration in decades has dedicated so much time and effort to the challenge of health systems reform. Since enactment of the Medicare system some 30 years ago, no other President has attempted to deliver such a detailed plan for health care for Americans.

Here are some of the major positive features of the proposal:

- Coverage: Some 34 million Americans who now lack health insurance will have it.
- Guaranteed Access: All Americans will be guaranteed access to health insurance. "Job lock" will be ended.
- Preexisting Conditions: Health plans will not be able to refuse coverage because of a preexisting health condition.

Sadly, while no President in recent memory has done more to propose improved access to mental health services, the plan does fall short of APA's objective for our patients of non-discriminatory coverage of treatment of mental illness (including substance abuse).

The President's health care reform package falls short of basic equity for the mentally ill in several respects:

- Coverage: Non-discriminatory coverage of mental illness will be "phased-in" over a 3 year period. At the start, the plan imposes limits on treatment that are not applied to other illness.

For example, outpatient psychotherapy is subject to a general limit of 30 visits per year, although additional visits could be made available at the option of the plan (and only to facilitate release from a hospital or to prevent hospitalization not facilitate appropriate medical treatment) but only by reducing the availability of inpatient care pursuant to a trade-off formula of 4 outpatients visits for 1 inpatient day;

inpatient hospital care is limited to no more than 60 days per year;

health plans are not required to offer non-residential alternatives to hospitalization, and alternatives such as partial hospitalization (where offered) would first have to be drawn down against inpatient days pursuant to a trade-off formula of 2 days of non-residential alternatives to hospitalization for 1 day of inpatient care.

- Cost Sharing: Patients will pay more out of their own pockets for treatment of mental illness than they will for other covered health services.

For example, in the fee-for-service plan, patients will pay 50% coinsurance for outpatient psychotherapy, a deterrent to treatment. For patients with severe illness who require hospitalization, the plan will require that they pay a deductible equal to the first day's hospitalization not required for physical illness hospitalization. This is a terrible burden for any patient, let alone someone who is ill enough to require hospitalization.

- Complexity: The mental health benefits are subject to an almost bewildering array of differential coinsurance, deductibles, visit limits, and trade offs between inpatient, outpatient, and partial hospitalization.

APA's experience with the health care system as it now exists does not bode well for the easy implementation and administration of the Clinton plan for mental health and substance abuse, and we are gravely concerned about retrospective efforts to have the treating professional reimburse the alliance for disallowed services.

APA agrees with the President's comments that "we can no longer afford to continue to ignore what is wrong" with our health care system. For the millions of Americans who struggle every day with mental illness and substance abuse, what is wrong is that they are treated differently just because of their diagnosis.

While we are also in agreement with Mrs. Clinton's testimony before Congress about the President's diagnosis of the need for national health care reform coverage of the treatment of mental illness, we respectfully disagree with the way the President has phased-in his prescription for change.

APA's medical prescription is to call on the Congress to improve the President's plan by treating persons with mental illness with the dignity and compassion they deserve. Congress can best do this by ending any artificial distinctions between the coverage of psychiatric illness and other medical illness.

In addition to determining the scope, duration, level, and type of benefits to be included in health care reform, the Administration, the Congress (and particularly the members of your Subcommittee), will also have to consider a host of complicated issues outlined below.

Mental Health Trade Offs

The President's proposal includes provisions which purport to provide "flexibility" in the mental health benefit, but which in fact -- unfortunately in our view -- represent a retreat from the limited initial benefit package laid out in the September 7, 239-page draft.

Of particular concern is the fact that the legislative proposal now makes the Intensive Non-residential Alternatives to Hospitalization an optional benefit, rather than a required 120 day benefit as it was in the earlier draft. Of equal concern is the fact that even where offered, the revised plan would require that the first 60 days of the Non-residential benefit reduce the inpatient benefit on a 2 for 1 exchange (i.e., 60 days of Non-residential care would eliminate 30 days of hospital care), as contrasted to the previously required 120 day alternative to hospitalization benefit.

In effect, the October 27 legislative proposal has gone from a required benefit total of 180 days of inpatient and intensive non-residential treatment (i.e., 60 days of inpatient and 120 days of non-residential care) to a required benefit of only 60 days of inpatient care, with an option of a total of 120 days of non-residential care, but with a trade-off which reduces the total benefit from 180 days to 150 days.

On the outpatient psychotherapy side, the plan provides for a discriminatory psychotherapy benefit, for 30 outpatient visits, at a discriminatory 50% coinsurance. The October 27 legislative language does permit additional outpatient visits but, again, these are provided at the option of the plan, and then only to prevent hospitalization or to facilitate earlier release from a hospital--rather than to facilitate appropriate medical treatment for the patient in accordance with the treating physicians judgment, and then at a 4 for 1 trade off for available hospital days. We are concerned that this is a illusory additional benefit.

In the coming months, you will undoubtedly hear a litany of suggested improvement in the President's legislation. APA believes that there are a whole host of benefit improvements in the mental health area which are worthy of careful consideration by the Congress. These include elimination of cost sharing for low income and indigent patients, special provisions for vulnerable populations such as the severely mentally ill, children and adolescents, and the elderly, expansion of the outpatient psychotherapy visit limit including elimination of discriminatory 50% patient cost sharing, and so on.

The APA urges the Congress to consider what is best for the patient as it deliberates on health care reform. We submit that benefit trade-offs, one-day deductibles, and discriminatory 50% patient cost sharing are not in the interests of the patient, and the 50% coinsurance will be a significant barrier to needed care for low and moderate-income persons requiring outpatient treatment. We also believe that Congress should include preservation of patients' rights to contract with their physicians without arbitrary restrictions which are at no cost to the system. APA strongly urges you to resist the blandishments of those who would have you "improve" a mental health benefit at the further expense of the patient or of other needed mental health benefits.

Global Budgets

Under the President's plan, the national health care budget will be established by the National Health Board. The budget is to be derived from the weighted average premium for the nationally-guaranteed benefits package in regional health alliances. This budget would be translated into a per capita basis (i.e., premium) and would vary regionally. The per capita premium times the number of individuals covered by the Alliance and adjusted for population age, health status and other factors forms the yearly global budget for that Alliance.

If the submitted average premium -- the bids offered by the Accountable Health Plans -- within an Alliance exceeds the premium target, an assessment is imposed on each plan whose bid exceeds the target, and on the providers receiving payment from the plan. Revenues from assessments on plans in excess of the premium target are used to reduce required employer premium contributions. The assessment on the plan is equal to a portion of the percentage amount by which the alliance target is below the bid.

Year-to-year premium increases are limited to the Consumer Price Index (CPI). If however, an Alliance's actual weighted-average premium in a given year exceeds its premium target, then the inflation factor for that Alliance is reduced for the following two years to recover excess spending.

Alliances may utilize various "tools" to meet their premium targets, including: premium negotiation, limiting enrollment in high-cost plans, freezing new enrollment, implementing surcharges on high-cost plans; and setting rates for providers.

While APA recognizes that equitable cost containment must be an essential part of any serious plan to reform the nation's health care system, it is not clear to us how global budgeting is likely to impact the delivery of services to persons with mental illness, and particularly to the most vulnerable populations of those with mental illness, including children and adolescents (who have no insurance of their own), persons with "severe" mental illness, the poor, and the elderly. Cost controls should not translate into little or no services for vulnerable populations or else into shifting persons into an underfunded and often non-existent state system of care.

Graduate Medical Education

The President's plan -- as would legislation already introduced in the House and Senate -- redirects graduate medical education away from specialties and toward primary care and increased investments in the training of non-physician providers. Within 5 years after the initial phase-in of the reform plan, at least 55 percent of physicians completing their residencies would be required to be in primary care medicine, defined as family medicine, general internal medicine, and general pediatrics, and obstetrics and gynecology.

The new National Council on Graduate Medical Education would be given sweeping powers to determine the number and distribution of every medical specialty, perhaps up to determining even how to distribute those positions across the U.S. depending on regional requirements for such specialties. For example, effective in 1998, the new National Council would be given authority to designate for periods of 3 academic years the number of individuals who may be enrolled in each medical specialty residency or other postgraduate training programs.

By academic year 2002-3, there is a specific requirement that the number of residents who complete eligible primary care programs must be not less than 55% of the total number of residents.

In addition to mandating that at least 55% of residencies are to be in primary care, the Clinton bill would create other incentives for primary care services, including a 10% primary care bonus increase in the Medicare RBRVS practice expense relative values, and a 10% increase in the RBRVS relative work values for office visits. There would also be a 20% bonus payment for primary care services provided in underserved areas.

These efforts will pose severe problems for psychiatric residency and training, presently defined as one of a very few medical shortage specialties by the National Council on Graduate Medical Education. The Administration's proposal would only significantly increase this shortage.

While psychiatry is not now defined in the statutes as a primary care specialty, psychiatry should not only be defined as such because of its "shortage" status but also because psychiatrists are the "primary care" physicians for the mentally ill. While there will certainly be a significant role for non-physician mental health providers, Congress should recognize that the services of physician and non-physician providers are not directly substitutable in all circumstances.

Meat axe proposals to address perceived overspecialization may unintentionally create or exacerbate shortages in needed specialties. APA believes that a more appropriate response to health manpower issues would be to expand opportunities to low-cost cognitive services in shortage, particularly emphasizing underserved geographic areas and public sector service (state hospitals, VA, etc.), rather than simply asserting a fixed policy that one-half of all new physicians should be "primary care" (however defined).

Medicare & Medicaid

As the Committee knows, a significant portion of the cost of paying for the new health care system under the President's draft proposal would come from capping and gradually reducing Medicare and Medicaid spending to the Consumer Price Index, with adjustments for population changes. Medicare and Medicaid spending cuts would be substantial: \$188 billion from 1996-2000.

APA is deeply concerned about the ability of these programs to sustain reductions of this magnitude without adversely impacting quality of care. Of particular concern to us is the fact that the President's plan does not propose to end existing discrimination against Medicare patients with a diagnosis of mental illness (such as the 50% coinsurance for outpatient mental health services or the 190 day lifetime limit on treatment in psychiatric hospitals).

Since the President's plan would otherwise phase out discriminatory limits on treatment of mental illness in the reformed health system, the distinct possibility is that the Medicare program -- generally among the more comprehensive coverage available today, may actually end up as significantly lesser coverage over time.

Managed Care

Inevitably, a central element in any health care reform plan -- whether the President's, single payer proposals, and so on, will be the increased use of utilization review and other means of managing the delivery of health care services.

APA does not oppose managed care per se. Indeed, based on a series of frustrating exchanges with the Administration's actuaries, we believe that we give more credence to the efficacy of quality managed care to control medically inappropriate utilization of mental health services than does the Administration's own cost experts. APA does, however, oppose the use of managed care techniques whose sole objective is to reduce costs without regard for the clinical needs of the patient.

APA strongly recommends that the Congress adopt rigorous Federal standards to ensure that the reformed health care system ensures the delivery of the appropriate care in the appropriate setting. Quality of care is a critical element in any reformed system, and we welcome working with the Congress for the adoption of criteria to protect patients from abuse as set forth in both the attached APA model bill on utilization review and managed care and so called URAC standards.

Conclusion

In conclusion, we know that timely interventions, including the use of psychotropic medications in conjunction with appropriate psychotherapy, can make an enormous difference to persons with mental illness, enabling them to resume a full and productive life. We also know that these treatments are clinically effective and cost effective. And we know that providing coverage for treatment of mental illness would save the nation nearly \$100 billion in annual indirect costs incurred from our failure to provide access to care today. We thus believe that coverage of treatment for mental illness should be included in whatever health care reform model the Administration ultimately puts forward.

The APA asks simply that psychiatrists and their patients be treated like all other physicians and patients are treated under a reformed health care system. We, and the medical treatments we provide, whether psychotherapy, psychopharmacology or ECT should be subject to the same cost constraints and the same internal reviews as are other physicians and patients. We should be subject to the same outcomes measurements as are imposed on other medical specialties and their patients. These studies will show what we have known all along: mental illnesses are real, can be clearly diagnosed, and can be treated effectively. The time for differential treatment, based on stigma rooted in fear and ignorance, is past.

The APA is heartened by the prospect of reforms to the nation's health care system, and particularly by the prospect that the opportunity for reforming the system as a whole will provide us with an opportunity to end discrimination against persons with mental illness and those who treat them. We hope your Committee and the Congress will seize the opportunity to redress the long-standing and unjustified discrimination against persons with mental illness which have been a feature of our health care system for far too long.

From the National Institute on Alcohol Abuse and Alcoholism
Contact: Stephen W. Long, Director, Office of Policy Analysis

Alcoholism and alcohol abuse are pervasive problems with far-reaching implications for health and for the economic and social well-being of individuals and society at large. Treatment for alcohol problems yields important benefits, including improved health, enhanced productivity, and reduced costs and utilization of health care services. Currently, treatment for alcohol abuse and alcoholism is reimbursed under many of the health insurance policies that cover American workers and retirees and their families.

The Need for Treatment

More than 15 million Americans suffer from alcoholism or alcohol abuse, of whom slightly more than half are under age 30.¹ These problems impose enormous costs on our society, both in economic and human terms. The projected economic cost of alcohol abuse in 1990 was \$98.6 billion. Less than 10 percent of this total was for medical treatment of alcoholism and alcohol abuse. Over 70 percent of these costs were in the form of productivity losses due to premature mortality and excess morbidity attributed to alcohol use.²

Alcoholism both causes and contributes to other health problems and thereby increases the use of health care services. Untreated alcoholics use health care services at a rate roughly twice that of nonalcoholics,³ and the

families of alcoholics consume more health care services than do those of non-alcoholics.⁴ People with alcohol disorders are overrepresented among hospital admissions, accounting for between 15 and 30 percent of all hospitalized patients.⁵ Many of these are undiagnosed alcoholics being treated for the consequences of their drinking. Acute and chronic conditions such as pancreatitis, liver disease, and repeated traumatic injury are often the result of alcohol misuse. Despite the well-documented relationship between alcohol disorders and poor health, physicians often fail to recognize and treat alcoholism.^{6,7,8}

Beyond the effects on health and economic productivity, alcohol problems exact a heavy toll in terms of human suffering. Failed marriages, anguished families, stalled careers, criminal records, and the pain of loved ones killed or disabled as a result of alcohol-related traffic crashes, violence, and suicide all testify to the destructive power of this disease.

The alcohol problems of adults are very real problems for their children as well. Children are especially susceptible to the adverse consequences of their parents' drinking. Some children are handicapped by the turmoil of living in an abusive family, and others are saddled with the social and psychological dysfunction that may result from growing up in an alcoholic environment. Adolescents may face increased risks of developing substance abuse problems of their own.⁹ The most tragic cases are children born with the profound physical and mental impairments associated with Fetal Alcohol Syndrome.

Alcoholism Treatment Can Help

The weight of evidence suggests that alcoholism treatment leads to reductions in the use of health care services. Total health care utilization and/or health care costs for treated alcoholics decline following treatment relative to matched non-alcoholics or to untreated alcoholics.¹⁰ Given the high rates of alcoholism among hospital patients, this suggests that alcoholism treatment may play a leading role in improving the Nation's health while at the same time helping to contain health care costs.

As with most medical conditions, there is no single treatment approach that is effective for all persons with alcohol problems. A treatment that works well for one individual may not work for another. Approximately 1.5 million Americans seek treatment for alcohol problems each year. Many recover and go on to lead productive, satisfying lives. Many others do not recover. Despite the best efforts of treatment professionals and the existence of multiple treatment options, many alcoholics relapse, requiring continuing or repeated treatment for their alcoholism. Relapse is a characteristic of many disease processes, including heart disease, cancer, arthritis, and diabetes. Indeed, a large proportion of the Nation's health care resources are devoted to the treatment of chronic, relapsing illnesses. As with these other disorders, the payoff from treatment can be measured in human and financial terms with every month of relief from the devastating effects of alcoholism.¹¹

Continuing research into the biomedical and behavioral aspects of alcohol problems will lead to more effective treatments in the future. Researchers are exploring new therapies and better ways of delivering therapies already shown to be effective, and these developments are eagerly awaited by the treatment community. In the crucial area of relapse prevention, for example, recent advances in pharmacotherapy raise the prospect of a medication to reduce the craving for alcohol.¹² Other research attempts to match alcoholics to the most effective treatment methods on the basis of personal characteristics¹³ and to identify the most effective treatment options for referrals by employee assistance programs.¹⁴ Continued investment in alcohol research promises to provide clinicians with more effective tools to help prevent relapse and to sustain long-term recovery.

Addressing the Problem

The need for access to treatment for alcohol disorders is recognized in current health insurance practices, in State regulations, and in the health care reform bills introduced in Congress. As of mid-1991, 40 States and the District of Columbia mandated insurance for alcoholism treatment, including 22 States and DC that mandated insurance coverage, and 17 States that required insurers to offer such coverage to their enrollees.¹⁵ Partly because of

these mandates, coverage for alcoholism treatment is available to many workers. In 1988, 83 percent of workers in private-sector firms employing 250 or more workers had coverage for alcoholism and alcohol abuse treatment, a substantial increase from the 36 percent who had such coverage in 1981.¹⁶

Alcoholism treatment is covered under the publicly-run health insurance plans that cover the elderly (Medicare), armed forces personnel and their families (CHAMPUS), and, to a lesser extent, the poor (Medicaid).

Given a reasonable consensus on the need for an insurance benefit to cover treatment for alcohol abuse and alcoholism, the details of insurance coverage for such treatment remain to be established. The structure of benefits will depend in part on the health care reforms enacted by the new Congress.

Whatever the nature of those reforms, treatment for alcohol disorders must be considered an essential component of basic health care. Whether covered separately or included as part of a more general benefit (such as for mental and addictive disorders), the treatment imperatives that are specific to alcoholism and alcohol abuse must be adequately reflected in health care reform proposals.

Design Principles for Alcoholism Treatment Benefits

The following principles should be observed in designing access to alcoholism treatment services:

Coverage must provide for a continuum of care relating to diagnosis of, treatment for, and rehabilitation from alcoholism. Detoxification services alone do not constitute an adequate benefit.

Patients and health care providers must have incentives to ensure that alcoholism treatment services are provided in clinically appropriate settings and in a cost-effective manner.

Benefits for treatment of alcoholism should be subject to limitations no more stringent than benefits for treatment and convalescence from other illnesses.

Alcoholism treatment services must not be denied nor limited on the basis of exclusions for existing or pre-existing health conditions, including history of alcoholism or alcohol abuse.

Advances in treatment that result from research developments must be made available to patients. This requires that insurance benefits provide adequate flexibility in defining covered services, since advances in treatment may not be foreseen.

Health care providers must be offered incentives that encourage early detection and prevention of alcohol problems.

Conclusion

Alcohol abuse and alcoholism are major health problems that afflict 15 million Americans and cost billions of dollars each year. Untreated alcohol disorders result in numerous acute and chronic health problems that impose a heavy burden on the health care system. Treating alcohol abuse and alcoholism can decrease health care utilization, increase productivity, and improve the lives of alcohol abusers, alcoholics and their families. Because of the wide-ranging effects of alcohol abuse and alcoholism on individuals' and society's health, economic and social well-being, treatment for these problems must be considered an essential component of basic health care. As such, health care reform in the United States must ensure access to alcoholism treatment for those who need it.

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American Academy of Child and Adolescent Psychiatry
November 8, 1993
to the
U.S. Senate
Committee on Labor and Human Resources

Hearing: Mental Health and Substance Abuse Benefits and the Health Security Act of 1993.

Introduction

The American Academy of Child and Adolescent Psychiatry appreciates this opportunity to submit testimony to the Senate Committee on Labor and Human Resources regarding the reforming of the health care system in this country.

American Academy of Child and Adolescent Psychiatry

The American Academy of Child and Adolescent Psychiatry is a national, professional association of over 5,600 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and a two-year residency training program in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and their families.

RECOMMENDATIONS FOR UNIVERSAL ACCESS: CHILD AND ADOLESCENT MENTAL ILLNESS SERVICES

Health care reform can mean a comprehensive change to a new benefit and payment system, or it can mean reforming the existing system of public and private insurers. Whether there is a move to a single payor system, a managed competition system, or a combination of proposals, children and adolescents with a mental illness will not be included in omnibus provisions if there is no allowance for their special needs. Legislative and regulatory recognition must be made for the differences in diagnosing and treating adults and children and adolescents.

The American Academy of Child and Adolescent Psychiatry supports a health care system that mandates equality between the insuring of treatment for physical and mental illnesses. Within the mandate, the special health needs of children and adolescents must be secured. The following three points highlight basic principles necessary to provide children and adolescents with mental illnesses with appropriate, quality care under any health care reform system:

Access and Nondiscrimination

- 1) **Children and adolescents have no access to insurance on their own. Provision should be made to include access for all children and adolescents, regardless of their family's status or income level.**

Children and adolescents with emotional disorders now have no assurance their illnesses will be identified, evaluated, diagnosed and treated. A large part of this problem can be traced to youngsters in situations where there is no insurance or where they are underinsured or they have benefits that discriminate against mental illness. Without adequate insurance, without treatment, these youngsters' health development is in jeopardy and they may have long-term, potentially costly consequences.

Up to eighty percent of children with untreated conduct disorders will have some contact with the criminal justice system. Unfortunately, conduct disorders are too often perceived as just bad conduct. It is not just "acting up," it is a serious emotional disorder that often is denied reimbursement for treatment. Other illnesses such as attention-deficit disorder and Tourette's disorders have had similar problems with reimbursement, often compounding the family and physician frustration and delaying treatment.

For children and adolescents, no treatment or undertreatment means a possible lifetime of unnecessary distress and underproductivity, a costly response in the short or long term.

Range of Services

- 2) **Services provided should include a wide range of treatment options -- including but not limited to preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, therapeutic foster parents, home-based services, detoxification and inpatient treatment. Treatment for children requires that services involve both the child or adolescent and family, interaction with the education system as well as appropriate collaboration with other significant care givers, teachers, physicians or providers of other needed services.**

- o Reimbursement for a range of services to treat emotional disorders has increased slowly. Innovations in treatment are inhibited by some reimbursement limitations. The system has tended to favor the most expensive treatment, such as hospitalization and not to include partial hospitalization or therapeutic daycare for the very youngest of those needing treatment. In the case of residential treatment, the shift has been from including to excluding it with no explanation and no addition of other services.
- o The use of inpatient services, like hospitalization and residential care, should not be discriminated against or unfairly capped because of misperceptions about cost or effectiveness. These are necessary treatments for children and adolescents with severe disorders. Community services for treating mental illnesses are often limited to inpatient facilities which restricts more appropriate treatment plan alternatives. Reform must support expansion of community services and adequate reimbursement for providing those services. Children and adolescents in treatment must continue to be nurtured and educated to avoid developmental delays.
- o Medicaid is designed to provide mental health services (to eligible children and adolescents). Medicaid's mandatory services for children and adolescents with psychiatric illnesses include outpatient hospital services, partial hospitalization, inpatient hospital and physician services, and services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 1989, Medicaid was amended to require the provision of treatment and follow-up services for problems identified through EPSDT screening even if the state does not normally cover such services through Medicaid.

Most states have not been able to comply with the expanded requirements, primarily for economic reasons that impede the training of screening personnel, the establishment of referral protocols, and the inability to reimburse for professional services at any more than a minimal level; however, the language of the law reflects a reliable model for both prevention and treatment of serious emotional disorders.

Cost containment

- 3) **Incentives should encourage the use of the earliest of interventions, the level of treatment necessary, treatment and management by an appropriately trained physician, and the most appropriate treatment setting possible, all of which would best serve the child's clinical goals in an economically prudent manner.**
 - o Managed competition is too often used for cost containment and has become equated with minimum care. Competition for contracts can lead to mental health benefit packages that discriminate solely because of the stigma of the illnesses involved. Children and adolescents with psychiatric illnesses often require complex diagnostic processes. Comorbidity is high in diagnoses such as conduct disorder or attention deficit disorder and adjustments in the treatment plan are often necessary. Inflexible packages obstruct even standard treatment plans for children and adolescents. Diagnosis of comorbidity requires trained child and adolescent psychiatrists. To miss a diagnosis and leave it untreated, lengthens the treatment and adds to the fiscal and developmental toll.

- o The use of managed care to control medical services must be regulated. The managed care industry's practices vary widely in organizational structure and quality. Reform will be compromised if regulation and oversight are not included. Improper utilization review can grossly compromise the treatment and significant psychiatric or physical harm may result. Too often, child and adolescent psychiatrists find that reviewers do not have enough knowledge about psychiatric treatment of young patients. Even medical directors, unless trained in child and adolescent psychiatry, make treatment plan review recommendations based on adult practice guidelines.
- o Case management is strategic to mental health care reform. Negotiating with agencies, resources, providers, and specialists is difficult and frustrating, and delays in treatment can result. Case managers must be trained to access a wide range of services and be appropriate in referring to those services.

In summary, reforming the health care system promises to be a stimulating, frustrating exercise, but the result will be worth the effort if universal access can be given to all Americans, if no illness is discriminated against, and coverage for every treatment is appropriate to the age of the patient.

Thank you again for this opportunity to submit testimony on the issue of mental health and substance abuse benefits and the Health Security Act of 1993. If you have questions or comments, please contact Mary Crosby, AACAP Director of Government Affairs, 202-966-7300.

William Ayres, M.D.
President
American Academy of Child and Adolescent Psychiatry

Statement

On Behalf Of:

American Academy of Child & Adolescent Psychiatry
American Occupational Therapy Association
American Psychiatric Association
American Association of Children's Residential Centers
Bazelon Center for Mental Health Law
Child Welfare League of America
Children's Defense Fund
Council for Exceptional Children
Family Service America
Federation of Families for Children's Mental Health
National Association of Homes & Services for Children
National Association of Psychiatric Treatment Centers for Children
National Association of State Mental Health Program Directors
National Education Association
National Mental Health Association
National Organization of State Associations for Children

The 16 national organizations listed above submit the following statement for the record. Our statement highlights the needs of children and adolescents with mental and emotional disorders and urges the Congress to protect these children's interests as the Health Security Act moves forward.

Children and adolescents with mental and emotional disorders now have no assurance that their illnesses will be identified, evaluated, diagnosed or treated. Many have no insurance, others are underinsured or covered by benefit packages that discriminate against mental and emotional illnesses. Without adequate insurance and without appropriate access to treatment these youngsters' lives are in jeopardy and many are destined to face long-term, costly consequences -- both social and financial. The President's Health Security Act, while addressing the problem of access, falls far short in meeting the service needs of children and adolescents needing mental health services in its initial, limited mental health benefit package.

While we applaud the President's inclusion of a fully comprehensive, flexible benefit in 2001, we do not believe it is necessary to wait into the next Century to provide the coverage children and adults so clearly require.

While the President is to be commended for proposing coverage of a broad array of services, we are extremely concerned about the impact of the arbitrary limits and the trade-offs which are proposed for the initial benefit. Until 2001, the President's plan will effectively eliminate the advances made recently in the delivery of mental health service delivery system for children because of restrictive and unrealistic limits on care and a system of trade-offs between benefits which is both detrimental to access and further erodes the limited benefit. What we will see is a service delivery system that continues to pay too little attention to clinical need. Removing the artificial limits would require health plans to assume full responsibility for these youngsters and motivate them to intervene early.

The following data highlight both the current problems in the system and the promise for a very different set of outcomes if we alter current reimbursement practices.

Our organizations urge the Congress to closely examine the data summarized here. We believe that Congress should include *in the basic benefit of the Health Security Act* the cost-effective mechanisms described below, so as to provide children and adolescents a full range of comprehensive mental health services which can be accessed as and when needed.

We can no longer tolerate the current situation, where lack of access by children and families to treatment is devastating children and adolescents, and resulting in long-term problems which cost our society billions of dollars in other social welfare programs. The inappropriate treatment of children also results in a possible *lifetime* of unnecessary distress and under-productivity.

Prevalence of Mental Disorders Among Children and Adolescents

Approximately 20% of all children and adolescents have a diagnosable mental disorder (Costello, 1989; Knitzer, 1982). About 3-5% of children suffer from severe mental disorders (MECA, 1993). Those children with severe disorders will require access to treatment through a full range of service options, particularly options that enable them to continue to live at home with their families. Many of these options have traditionally not been available through insurance plans.

In addition, the incidence of mental and emotional problems among children and youth in the care of various state administered systems are simply shocking. For example, somewhere between 50% and 85% of the 430,000 children in our nation's foster care system have a diagnosable mental or emotional disorder. Similarly, it is estimated that over 60% of the approximately 94,000 adolescents detained in juvenile justice facilities across the country have substantial mental health or substance abuse problems, while state special education programs serve over 390,000 children with serious emotional disturbances.

Lack of Access to Services

Studies have found that a significant proportion of the children with mental and emotional illnesses do not have access to services. Between 70-90% of children with severe disorders are not receiving mental health services, and only 2-6% of all children with mental or emotional disorders receive some form of mental health care (Costello, Angold, Burns & Leaf, 1992; MECA, 1993, Burns, 1990 and Bickman, 1993).

Prevention and early intervention services have been underfunded and relatively unavailable in the foster care and juvenile justice systems. In many instances, children receive direct services only after mental health problems have become manifest.

Appropriate Services for Children

Calls for the development of comprehensive, community-based systems of care for children with mental health disorders date back to the Joint Commission on the Mental Health of Children in 1969. The Commission's report found that these children were typically unserved or served inappropriately because of the lack of available models of appropriate care. These findings have since been substantiated by numerous studies, task forces, commissions and reports -- including reports from the Office of Technology Assessment and the Institute of Medicine -- all of which concurred that coordinated systems of care providing a broad range of services are required to meet these youngsters' needs.

Systems of care emphasize comprehensive and individualized services, furnished within the least restrictive most appropriate environment, with the full participation of families. The coordination among public child-serving agencies and programs is also a quintessential ingredient in the provision of appropriate care to these young people. The system of care approach represents not only a network of services, but a philosophy about the way in which services should be delivered, based on the individual needs of the child and family.

Despite a ten-year federal demonstration program (Child and Adolescent Service System Program, CASSP), which evidenced the effectiveness of such systems of care, it has only been relatively recently that any examples of this approach have emerged. Such systems have begun to blossom around the country as federal, state and local governments, as well as foundations, have sponsored activities in this field.

There currently is widespread consensus that community-based systems of care represent the state-of-the-art in treating children with serious emotional disorders, and the development of such systems has become a national goal. Indeed, this Committee led the way in approving the Child Mental Health Services Program in 1992, to stimulate the development of such systems in states and communities across the country (enacted as part of PL 102-321, the ADAMHA Reorganization Act).

It is especially important now, as Congress considers the issue of health care system reform, to examine what we are learning about systems of care for children and to ensure that the reformed health care system represents true reform -- reform that encourages the provision of the most appropriate care for children and youth with mental and emotional disorders, in a flexible manner, based on clinical needs.

Data on Comprehensive Services for Children

Comprehensive, managed systems of care (or managed benefits) for children with mental and emotional disorders can be found in the private and public sectors.

In the private sector, many large company health care plans now include a comprehensive and flexible managed benefit that includes inpatient services, residential treatment, day treatment and outpatient care. Experience with these plans generally shows that the comprehensive and flexible approach is preferable and more cost-effective than a traditional insurance benefit.

In the public sector, through public funds or private foundation support, several systems of care are now operating. Some, such as the Robert Wood Johnson foundation's children and youth project, target children with the most severe disorders, while others target a broader population. According to a recent compilation of results from a number of studies (Stroul, 1993), outcomes from all such systems show a consistent pattern:

- Reduction in out-of-home placements;
- Reduction in out-of-county and out-of-state placements;
- Increase in stability of placements;
- Reduction in utilization of inpatient services;
- Reduction of length of stay in inpatient settings;
- Reduction in utilization of residential treatment center services;
- Reduction in length of stay in residential treatment centers;
- Increased use of less restrictive and more appropriate placements.

In addition to these reductions in more traditional and often more expensive care, these systems also demonstrate success in improving outcomes for these youngsters. Such systems show:

- Improved functioning on both specific behaviors and globally;
- Improved school attendance;
- Improved school performance;
- Improved school placement status;
- Reduced contacts with law enforcement;
- Reduced incarceration and recidivism rates for juvenile offenders;
- Increased parent participation and support; and
- Increased parent and youth satisfaction with services.

The newer approaches to provide comprehensive and flexible mental health coverage are now yielding cost analyses:

- In Fort Bragg, North Carolina, the average cost per client in a system of care is approximately \$5,380 as compared with \$10,992 at comparison sites (51% lower).
- In Kentucky, the Impact program is less costly to serve youngsters with an array of community-based services when compared with the previous, less comprehensive system. Under Impact, estimated costs were \$9.5 million compared with \$13.5 million for the prior year -- per child costs were reduced about \$4,300 (from \$19,539 to \$15,244).
- A state-wide approach in Vermont showed it was less costly to serve children in individualized services than in out-of-state residential placements. Average cost per child was \$57,218 for 10 youngsters in out-of-state placements for approximately 9 months, compared with \$43,025 for 19 youngsters in individualized services for at least 9 months (including education costs).
- In Ohio, costs for children receiving individualized services was 10% less (in a 6-month period) than previous costs with a traditional approach.

Overall, several systems have estimated costs that have been avoided by establishing comprehensive and flexible systems of care:

- Three comprehensive systems in California have saved over \$35 million in expenditures that would otherwise have been paid for group home residential care from 1989 to 1992. If all California counties had followed the same trend by utilizing systems of care, the state could have saved \$520 million in that period.
- In Ventura County, California, costs avoided by reducing youngsters' involvement in the child welfare, criminal justice or psychiatric hospital systems during 1985-1988 (period of the demonstration) were estimated at \$2,873,981.

- Family Mosaic, in California avoided costs by reducing the number of days of detention by 252 total days (\$50,178 for one year); and by reducing the number of days of psychiatric hospitalization (\$187,000 to \$102,000 for one year).

Clearly, community-based services have significant data from major controlled studies which demonstrate their effectiveness in improved outcomes for children, improved placement patterns with higher rates of services in less restrictive settings and in reducing costs. (Hoagwood, 1993).

Clinton's Health Security Act

The Health Security Act would provide access to a broad and extremely important array of services for children and adolescents with mental and emotional disorders. This range of services is similar to the range provided through the systems of care described above, and includes:

- Screening and assessment;
- Diagnosis;
- Day treatment and psychiatric rehabilitation;
- Behavioral aide services;
- Collateral services (for family members);
- Case management;
- Psychotherapy;
- Medical management;
- Family foster care;
- Group homes
- Crisis intervention;
- Crisis residential programs;
- Partial hospitalization;
- Residential treatment centers;
- Inpatient psychiatric hospital services.

However, the Plan imposes limits on these services: 120 days annually on intensive community services, 30 sessions per year of psychotherapy and 60 days annually, and 30 days per episode, limit on inpatient/residential care. Access is also restricted for certain services: additional days of psychotherapy may be covered, but only if the child would otherwise be hospitalized, the 30 day episode limit on residential treatment can be exceeded, but only if the child is found dangerous (a standard that is unlikely to apply to children). In addition, a complex set of trade-offs is provided, so that intensive community services can only be used if the family is willing to surrender inpatient/residential coverage, and use of the extended psychotherapy benefit also draws down on the inpatient/residential coverage.

The Health Security Act also proposes both continued authority for states to provide Medicaid services to eligible SSI and AFDC individuals, and authorizes a new federally-financed program for low-income children previously eligible for Medicaid. In a number of states, this could result in Medicaid-eligible children having access to the full range of services, without limits or trade-offs, since many states now include the components of a system of care for children under their Medicaid plans. While it is not yet clear whether this language protects all currently eligible groups of children, we urge the Congress to retain provisions to protect Medicaid-eligible children from cutbacks in their benefits as the legislation moves forward. It is critically important, as we move to expand access to health care for all, not to undercut the current services made available in many states to low income children with serious emotional disturbance.

Conclusion

In health care reform, we have a unique opportunity to create a system which will assure that care is delivered both responsibly and appropriately, and commensurate with need. Indeed, the fully comprehensive, flexible benefit the President proposes in 2001 would accomplish that goal. Historically, the health insurance industry has fostered a system of care built around a specific payment structure and as a result, care is not always delivered based on need. We need to break this pattern and, as referenced above, models of delivery do exist to accomplish that and to provide service based on need.

The 16 organizations listed on this testimony, while applauding much of the President's plan, nonetheless urge the Committee to waive the limits on mental health services for children and adolescents now contained in the Health Security Act and delete the trade-off requirements with respect to child and adolescent services. This would grant our young people true security through access to the appropriate range of services as and when they need them. Anything less will condemn many youngsters to an ineffective level of care, to being removed from their families unnecessarily and it could set them on a path that leads to lifetime dependency on (or conflict with) society.

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Knitzer, J. (1982). Unclaimed children. Washington, D.C. Children's Defense Fund.

MECA (1993). Methodological epidemiological catchment area study. Preliminary findings. Unpublished data.

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Bickman, L. (1993). Evaluation and research issues in system of care research at Fort Bragg. Paper presented at the 6th annual research conference of the Florida Research and Training Conference, March 1993.

Hoagwood, Kimberly, Ph.D., Research on the effectiveness of mental health services and service systems for children and adolescents with mental disorders: A brief overview of the issues. National Institute of Mental Health, Rockville, Md. 1993.

Stroul, Beth A., Systems of care for children and adolescents with severe emotional disturbances: what are the results? Georgetown University Child Development Center, Washington, D.C., 1993.

The American Psychological Association

Chairman Kennedy and Distinguished Members of the Committee, the American Psychological Association, the largest membership association of psychologists with more than 118,000 members engaged in the study, research, and the practice of psychology, greatly appreciates the opportunity to submit this testimony to the Labor and Human Resources Committee for the record.

The APA thanks Chairman Kennedy for his many years of leadership in addressing our nation's health care crisis, and we are grateful for the heroic efforts that many Members of this Committee have taken to see that the mentally ill partake in the promise of national health care reform; the promise that they will receive the care which they need and deserve as human beings and as citizens of our nation. We look forward to assisting the Members of this Committee during your extensive and searching review of President Clinton's health care proposal and in your vital efforts to reform our country's health care system.

The APA commends President and Mrs. Clinton for the enormous leadership that they have shown in presenting to Congress a detailed health care plan and particularly for the attention that they have given to the needs of the mentally ill. The President's plan contains much to applaud: the promise of comprehensive health benefits that cannot be taken away for any reason; reform of the insurance market to end insurance industry practices which "game" the health system through pre-existing condition exclusions, adverse selection, discriminatory premium rating and other practices which protect profit margins while locking people out of health coverage; and, initiatives that promise access to health services regardless of geographic, socioeconomic, or cultural status or background.

While the President's plan offers much hope for the mentally ill, today we will focus on ways that Congress may improve the plan so that mentally ill persons may receive the care they need through the most cost-effective means. As psychologists, we are deeply and uniquely involved with the needs of the mentally ill and the system in which they presently receive care. The APA has developed a statement called "Principles for Mental Health and Psychological Services in Health Care Reform." As our principles statement attests, we believe the people of our nation should have access to a continuum of mental health services including: preventive, emergency, outpatient (including appropriate levels of psychotherapy, psychological rehabilitative, and neuropsychological) services, diagnostic testing and assessment, inpatient and residential treatment, prescription drugs, and additional services for children, adolescents, women, and other persons with special needs. Our principles statement outlines our belief that, by removing the inefficiencies in the current mental health delivery system, a continuum of quality mental health services may be offered cost-effectively. The APA respectfully submits our principles statement for the record, attaching the statement to our testimony.

Mental illness devastates the lives of those afflicted and drains our society and economy of needed resources. The comprehensive benefits package must cover mental health and substance abuse services.

The human suffering caused by mental illness and substance abuse addiction exact a tremendous toll on our nation. Right now, 15-18% of Americans, including 14 million children, suffer from a diagnosable mental disorder. 50-70% of visits to primary care physicians are for medical complaints that stem from psychological factors. In any one-month period, nearly eight million Americans suffer from depression, and as many as one-in-five Americans will suffer at least one major episode of depression during their lifetimes. A random study of elderly residents in Medicaid facilities determined that nearly 80% of the residents had moderate to intense needs for mental health care.

Mental illness and substance abuse addiction lower our national productivity, costing our economy billions of dollars each year. As of 1990, mental illness cost society an estimated \$129.3 billion annually, about half of which was found attributable to lost productivity in the workplace. In 1990, the number of lost work days associated with major depression alone, cost our economy \$23 billion, and we now believe that minor depression, which affects more people, may account for 51% more disability days than major depression. A three year study of a large corporation concluded that 60% of employee absences were due to psychological problems.

Even when workers are not absent, mental illness decreases on-the-job productivity. Mental illness, including depression, can be as functionally disabling as a serious heart condition and more disabling than most other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension, and even diabetes. We now believe that mental illness is the condition that most limits the ability to work, and mental illness is the third most limiting health condition in terms of performing major daily activities with only cancer and stroke being more debilitating.

Our society is terribly burdened by the cost of untreated mental illness and substance abuse addiction. Nearly 1/3 of our nation's homeless suffer a severe mental illness. A majority of the

30,000 suicides in this country each year may be attributed to a psychological or substance abuse disorder. The costs associated with the lost contribution to our nation due to the inability of so many of our people to receive appropriate and timely mental health care is unmeasurable but undoubtedly staggering.

The comprehensive benefits package must cover mental health and substance abuse services, because these services are effective, reduce the costs associated with physical illness, and increase economic productivity.

A wide array of outpatient and inpatient psychological treatment interventions are available and proven to effectively treat persons suffering from mental illness and substance abuse addiction. The treatment success rate of psychological interventions for several major mental disorders is impressive, surpassing many of the success rates for medical interventions. Psychological services successfully treat 70-90% of anxiety and stress disorders, 80% of both manic and depressive bipolar disorders, 70-90% of major and minor depression, 60-80% of the cases of substance abuse, and 60% of schizophrenia. Compare the effectiveness of these psychological interventions with two common medical interventions: angioplasty has a 41% treatment success rate and atherectomy, a 52% success rate. In the health care system, dollars directed towards psychological services buy successful outcomes for people suffering from mental illness.

Mental health and substance abuse treatments are cost-effective and reduce the costs associated with physical illness. Mental health costs have remained relatively constant over the last 20 years, constituting approximately 9-11% of direct treatment costs. Mental health and substance abuse treatments combined rank only 25th as a factor influencing health care cost increases.

In addition to cost stability, mental health services reduce the costs associated with the treatment of physical illnesses. Studies have shown that general inpatient medical care can be cut by as much as 70% following mental health treatment, and outpatient utilization may be lowered by as much as 20%. Several studies have conclusively demonstrated the cost-savings associated with psychological interventions: In a study of the Federal Employee Health Benefits Plan, patients with chronic medical diseases who received psychotherapy services consumed 56% fewer medical services than those patients who did not receive psychotherapy. Medicaid patients hospitalized for physical ailments and provided mental health interventions realized average cumulative savings of \$1,500 over a 2 and 1/2 year period, and the cost of the the mental health intervention was entirely paid for by the decrease in medical services utilization. And a three year study of over 10,000 Aetna beneficiaries showed that after initiation of mental health treatment, beneficiary medical costs dropped continuously over a 36-month period; the health costs of one mental health treatment group fell from \$242 the year prior to the treatment to \$162 two years after treatment, and other subject groups experienced similar dramatic decreases.

As we have mentioned earlier, mental illness damages our nation's productivity and hurts our economy, but fortunately, we know that mental health treatment restores productivity in the workplace. For instance, one study determined that prior to inpatient substance abuse treatment, 42% of the individuals in the study reported absences due to drugs and 39% reported tardiness. One full year after treatment, these numbers had dropped to 5% and 7% respectively. The McDonnell Douglas Corporation, by implementing an employee assistance program, reduced employee terminations of those individuals participating in substance abuse program by 42% and for those participating in the mental health program by 28% over a four year period when compared to those employees in the traditional health program. Over a five year period, the employee assistance program reduced absenteeism by 29% and 25% for those in substance abuse treatment and mental illness treatment programs respectively.

Outpatient mental health services hold the promise for the delivery high quality and cost-effective services in the reformed health care system.

Outpatient mental health services, particularly outpatient psychotherapy, are generally as effective as inpatient treatment and may be delivered for a fraction of the cost. The ability of the

reformed health care delivery system under President Clinton's plan to contain mental health and substance abuse costs while providing our people with high quality mental health care will be greatly enhanced if the use of outpatient psychotherapy and other outpatient services is encouraged through the incentives contained in the comprehensive benefits package.

Facing skyrocketing mental health costs, many businesses across the United States have already moved to a mental health benefits structure which encourages the use of outpatient benefits. Their results have been dramatic. In 1989, BellSouth Corporation adopted a mental health benefit that encouraged employees to receive care in the least restrictive setting. Within three years after implementation of the new benefit structure, BellSouth's total mental health bill decreased by \$6 million, and the portion of their total health costs attributable to mental health fell from 17% to 9.2%. In one year Chevron saw a 21% decrease in psychiatric hospital admission costs due to the implementation of a provider network that encouraged outpatient mental health care and intermediary services. First National Bank of Chicago saved 30% in mental health and substance abuse costs over four years as a result of a redesigned mental health benefit that expanded their range of services covered and reimbursed outpatient care at 85%.

Many businesses like BellSouth, Chevron, and the First National Bank of Chicago have discovered that high quality, cost-effective mental health care can be delivered through outpatient care. Fortunately, the Administration has noticed the successes of these businesses and is implementing a flexible mental health benefit in the comprehensive benefits package which will allow relatively inexpensive outpatient psychotherapy services to be "substituted" for inpatient services in appropriate circumstances.

The mental health benefit in the comprehensive benefits package of the President's plan must be further refined to encourage the use of outpatient psychotherapy services.

The "substitution" of mental health benefits towards inexpensive outpatient psychotherapy services, will ensure that enrollees under the new health care system receive appropriate, high quality, and cost-effective mental health care. Under the present health care system, insurance companies typically limit mental health benefits to reduce their reimbursements. These limits commonly lead to cost-shifting to families and individuals to pay for the balance of the treatment or termination of treatment prior to successful outcome. Insurance expenditures might be saved, but undoubtedly, costs to the overall system rise as repeated and more expensive care is consumed to treat of the individuals as they utilize later annual limits.

By allowing the substitution of outpatient for inpatient benefits, the Administration has avoided the danger of relying too heavily on inpatient treatments, which we believe would have driven up expenditures and ultimately led to further limitations on the aggregate benefit to the detriment of all persons needing mental health services. Essentially, the substitution will allow outpatient psychotherapy benefits to be provided through an equivalency multiple to the hospital inpatient day limit. In appropriate circumstances, therefore, additional outpatient psychotherapy visits will be available to needy patients through direct substitution of inpatient benefits.

Outpatient psychotherapy offers relatively inexpensive and effective care for the entire spectrum of mentally ill individuals, including seriously mentally ill persons. Through substitution, President Clinton's plan allows for treatment for significant patient populations through more appropriate outpatient services. All evidence indicates that recent increases in mental health care costs have occurred only in inpatient alcohol and drug and inpatient adolescent care treatment settings. Research now concludes that nearly 50% of these patients could be treated as effectively or more effectively in outpatient settings. As Senator Wellstone has pointed out in a very recent article, "We can treat ten people once a week for a year of outpatient therapy for what it costs to keep one person in the hospital for 30 days."

The outpatient psychotherapy benefit. Psychologists and many other mental health providers are extremely concerned with the inadequacy of the outpatient psychotherapy benefit outlined in President Clinton's plan. The 30 visit outpatient psychotherapy benefit at 50% copayment in relation to the extremely generous inpatient and partial hospitalization benefit will do no more than codify the current inefficiency and inequity in the mental health delivery system, denying humane care to millions of mentally ill persons and promising to waste billions of dollars in the system.

For many mentally ill persons suffering from a wide range of mental illnesses, including those with persistent mental disorders and children, who often are best served through least-restrictive outpatient psychotherapy, 30 outpatient visits will not offer effective treatment. Research demonstrates that persons with severe mental illness show improvement after 26 sessions. Through substitution, President Clinton's plan promises that these individuals will receive the amount of additional psychotherapy that they need and that they will not be locked out of effective treatment by an arbitrary 30 visit limit.

Actuarial substitution for additional psychotherapy. The President has taken a major step toward ensuring that mentally ill persons receive adequate and appropriate levels of psychotherapy by allowing an actuarial substitution of the inpatient hospital mental health benefit for additional psychotherapy visits. We know that the cost associated with permitting additional psychotherapy is minimal; for instance, the removal of a 30 visit limit to an outpatient psychotherapy benefit without arbitrary limit increases total mental health and substance abuse costs by a mere 3.2%. This minimal increase in mental health costs would offer invaluable and appropriate treatment for seriously mentally ill persons who would otherwise be improperly funneled into inpatient settings. At the same time, the mental health delivery system would be more effective in containing costs through the reduced use of inpatient hospitalization.

Unfortunately, under the Administration's plan mentally ill persons may never be permitted to access the additional psychotherapy that they need. The proposal authorizes the health plan to determine the patient's need for additional psychotherapy through the actuarial substitution. Additionally, the substitution is only available "to prevent hospitalization or to facilitate earlier hospital release." Considering the long and unfortunate track record of the extreme limits that managed care has placed on psychotherapy services, we believe that health plans in the new system will ignore patient need and refuse additional psychotherapy sessions.

President Clinton's "managed competition" plan relies heavily on managed care. Managed care entities, and more recently, other third-party payers, have redefined traditional outpatient care to make it as brief as possible. These entities have so often egregiously limited care, reimbursing only a fraction of the available benefit, that those mentally ill persons in greatest need of care, essentially receive no care.

In addition to the potential denial of the use of the entire 30 visit psychotherapy benefit, we can easily envision a system where health plans uniformly deny the additional, substituted outpatient psychotherapy benefit for enrollees, even in instances where these persons desperately need to continue their treatment. Therefore, actuarial substitution must be mandated, determined by a health professional, and not left to the discretion of the health plan. In addition, eligibility for additional visits must be based on a determination that psychotherapy is medically or psychologically necessary, or that it is the most appropriate form of treatment and that inpatient and intensive nonresidential treatment would be ineffective or inappropriate, as is often the case.

The 50% copayment for outpatient psychotherapy. Like the 30 visit psychotherapy limit, the 50% copayment will provide incentive to use expensive and often inappropriate inpatient treatment into the reformed system. If this occurs, this incentive will reproduce the short-sighted and irrational present structure, where the insurance and hospital industries are promoted and adequate outpatient care is ignored.

In 1984, the Medicare PPS/DRG system was established so as not to apply to psychiatric units or hospitals. As a result, entrepreneurial dollars were directed into psychiatric facilities, and the number of psychiatric facilities doubled between 1984 and 1988. The result has been, in some cases, disaster, because the explosion of facilities led to "provider demand" for patients, allowing some inpatient providers to abuse the system.

Consider the case of National Medical Enterprises (NME), one of the largest psychiatric/rehabilitation hospital chains in the country. Federal and several State authorities are currently investigating NME on charges that several of its facilities paid "bounty hunters" to snare patients and hold them against their wills in order to receive their insurance reimbursement. NME awarded bonus payments to psychiatric hospital managers for high occupancy rates. Hundreds of patients are now suing NME, relating how they were cruelly treated then miraculously released as "treated" when their insurance coverage ran out.

The 50% copayment for outpatient psychotherapy is relatively high when compared to the inpatient mental health cost-share. As in the present system, the President's plan will pose for the families of mentally ill persons the burdensome alternative of keeping the family member at home with no outpatient treatment, because the cost-sharing is too expensive for them to afford, or using hospital-based services, giving themselves respite and eliminating their financial burden. It is this dual dynamic which has driven costs in the present mental health system. Unfortunately, President Clinton's plan seeks to implement this inefficiency into the reformed mental health delivery system.

People in the reformed system should be encouraged to utilize unlimited outpatient psychotherapy at copayment rates that are similar to inpatient cost-share. At a minimum, people needing outpatient psychotherapy should be permitted to pay for services on a sliding scale according to their income and to apply their co-payments to the aggregate out-of-pocket limit provided to protect families in the comprehensive benefits package from inequitable and unconscionable financial burden. Reducing the copayment burden on families will produce some cost to the total mental health and substance abuse system but has the greater potential to prevent gross overspending in the much more expensive inpatient system.

In conclusion, we would emphasize our strong belief that the President's mental health benefit, with its emphasis on expensive inpatient mental health care, will burden the reformed system with the warped incentives that have limited patient access to care and spiraled systemic mental health costs. The outpatient psychotherapy benefit is so comparatively limited and the inpatient benefit is so rich, that we believe that mental health outlays will skyrocket, which could eventually lead to a tragic scaling back of mental health benefits and access of the mentally ill to adequate treatment.

The actuarial substitution of inpatient benefits for outpatient psychotherapy offers a step towards a more cost-efficient and appropriate system of mental health care, but the plan must be redesigned to ensure that benefit substitution is accessible and available at cost-share rates which are fair and encourage the use of the psychotherapy benefit.

Consumer protections must be implemented to prevent managed care abuses.

We have already indicated our concern that health care plans in the "managed competition" system, through managed care techniques, will work to impinge on appropriate patient care. Because the actual delivery of all services, particularly mental health services, in the comprehensive benefits package will depend heavily on determinations made by managed care entities and through managed care techniques, we find particularly disturbing the fact that the Health Security Act contains no specific guidelines to protect the system from the abuses of unbridled managed care.

The managed care financial incentive structure is designed to contain costs by rationing mental health care, instead of addressing the specific needs of the patient. When the provider of care stands in a financial conflict of interest with the recipient of care, the availability of care is jeopardized. Providers are rewarded for limiting care, and patients who are promised a 30 patient limit will likely receive a fraction of their benefit. It is this financial conflict of interest of the provider which jeopardizes patient care.

Scrutiny of managed care should be heightened due to a Government Accounting Office (GAO) study, released just last month, which has concluded that there exists no conclusive evidence that managed care health plans save money. The study concluded that managed care plans saved money by enrolling younger and healthier persons not by efficiently managing patient care, and that in one study, HMO premiums averaged only 2-4% less than other plan premiums in 1992. This finding directly challenges the President's plan premises that moving beneficiaries into managed care structures will contain costs.

Since managed care will be a foundation of the reformed health care system under the Clinton plan, strong quality standards to protect the patient and to reduce rationing of care must be implemented into the statutory language. We suggest that the National Health Board might be empowered to develop and enforce managed care and utilization review standards, but whatever the vehicle, at a minimum plans should be required to:

- ◆ separate clinical review from financial interests;
- ◆ adhere to quality standards which protect the patient;
- ◆ use reviewers who are licensed or certified in the areas of mental health care under review;
- ◆ make public the review standards and criteria used in evaluating health care plans;
- ◆ establish arbitration to resolve appeals;
- ◆ ensure that patient confidentiality is protected;
- ◆ implement a review and appeal system which reviews decisions quickly; and,
- ◆ maximize patient choice of services and mental health providers.

The President's plan contains scattered references to some of these protections including: protection of the privacy of patient data, implementation of a National Quality Management Program to develop a quality information and accountability program to be applied to health plans, and a vague provision which may mandate that managed care entities publish their protocols for determining care and containing costs. However, the plan does not contain specific and strong patient protections against potential managed care abuses. We strongly believe that these patient protections will ensure that patients are protected and that managed care companies effectively operate to manage care rather than ration care.

Nonphysician provider services must be encouraged in the reformed system.

Psychologists and many other nonphysician mental health providers are concerned that the Clinton plan may fail in its stated purpose of ensuring that patients have an effective choice of providers. The Health Security Act must ensure that qualified nonphysician providers are able and encouraged to render their services in all settings where appropriate, and in so doing, the plan will meet its goal of providing access for patients to all qualified health professional services.

Inappropriate restrictions on nonphysician providers. Although the President's plan does much to eliminate the inappropriate and noncompetitive strangle hold that physicians have held on the health care system through archaic and restrictive statutory and regulatory language, many

provisions may continue the tradition of inappropriately prohibiting psychologists and other nonphysician mental health providers from rendering care to their patients. Areas of particular concern are:

- ◆ The plan defines health providers and nonphysician health providers in terms of their ability to render "physician" services. This definition is archaic and incompatible with the purpose and goals of the health plan. Instead, health professionals and the services that they provide should be defined according to their individual skills and training. In addition, States, health alliances, and health plans should ensure that enrollees in the system have access to a sufficient range and mix of providers and specialty providers.
- ◆ The plan must define hospital and other inpatient settings so that patients do not lose access to nonphysician provider services and eliminate restrictions in current law that pose barriers or prohibit nonphysicians from practicing in accordance with State law. Of particular concern to psychologists is the indication that the President's plan will apply the Medicare "hospital" and "psychiatric hospital" definitions to the entire system. Since the Medicare hospital and psychiatric hospital conditions of participation provisions improperly require physician supervision of patient care, psychologists in several states will lose their present ability to independently supervise and render care for their patients in these settings. Therefore, to ensure access of all patients to qualified psychologists services, the plan must drop the Medicare hospital and psychiatric hospital definitions and ensure that psychologists and other nonphysician providers are able to care for their patients according to their training and competence. Additionally, the plan should eliminate arbitrary barriers to hospital membership and appropriate clinical privileges.
- ◆ Several provisions in the plan, such as the provisions relating to antitrust enforcement and "safe harbors" in the new system, inappropriately apply only to physicians. These must be reexamined, and psychologists and other nonphysician providers must be included where appropriate.
- ◆ The plan must eliminate all discriminatory and anticompetitive practices against nonphysicians. Specifically, the plan must include language which prohibits health plans from discriminating against any class of health professional. In this way, enrollees are able to access the full range of available providers in their area, and the Health Security Act will accomplish its stated goal that "individuals in the United States should be afforded a meaningful opportunity to choose among a range of health plans, health care providers, and treatments." Relatedly, the plan must ensure an appropriate and sufficient mix and representation of all health professionals on the national, regional, and State health boards and health plans.

Psychologists' services in rural and underserved areas. Of particular concern for psychology is the impact of nonphysician restrictions in rural areas. Two-thirds or more of all U.S. counties do not contain a single psychiatric physician, while psychologists are more widely dispersed and available to render mental health services.

President Clinton's plan has proposed to expand mental health services access in rural areas through investment in inpatient and non-residential infrastructure. While infrastructure investment is important in some cases, the system must include incentives for enrollees to use the least costly, most accessible forms of community-based and health professional services in underserved areas. Effective outpatient services rendered by psychologists and other nonphysician mental health professionals are currently available in rural and underserved areas.

The plan must encourage psychologists and other mental health providers to offer their services in rural areas. The plan offers educational and financial incentives, such as a non-refundable personal tax credit and a deduction of up to \$5,000 in annual student loan interest, for primary care and certain other professionals to render services in rural areas. Given psychology's excellent track record in delivering mental and behavioral health care in rural areas, these provisions should be expanded to include psychologists.

Psychological and neuropsychological services. Within the specifications of the comprehensive benefits package, the APA voices concern that psychologists may not be permitted to offer their services for certain populations for whom they now typically render care:

- ◆ The mental health benefits in the comprehensive benefits package must include the full range of psychological and neuropsychological services, including diagnostic and assessment services. These services are widely consumed in the United States, and psychologists, possessing the most diverse and comprehensive armament of screening and assessment tools in the mental health arena, are typically relied upon to provide these services.
- ◆ Psychological and neuropsychological services are typically used in the rehabilitative process to assess, remediate, and restore the cognitive functioning of patients who are impaired as a result of a variety of physical illnesses and injuries. The comprehensive benefits package should be amended to include psychological and neuropsychological services as part of the outpatient rehabilitation benefit.

The APA specifically requests Congress to protect the participation of nonphysician providers, including not only psychologists but social workers, nurses, optometrists, podiatrists, chiropractors and other groups who have a pro-competitive impact on health care costs and provide very cost-effective alternative treatments. We hope that Congress will be very careful in its review of the language of the Administration's plan to make sure that vaguely articulated provisions in the legislative draft are clarified to provide for the full range of nonphysician services.

Conclusion.

In our testimony, we have emphasized those areas directly related to the delivery of psychological and mental health services. However, we have significant questions about a number of the more general features of the plan, particularly the formation and operation of accountable health plans, the development and authority of the National and Regional Health Boards, and the development of systems to evaluate quality of care and provider performance. While this forum does not permit a thorough discussion of these issues, we will seek further opportunities to discuss these issues with you, Chairman Kennedy and Members of the Committee as you continue to examine the President's proposed legislation.

The APA commends the President and Mrs. Clinton for their enormous contribution in advancing health care reform, and in particular, their unwaivering leadership in developing mental health policy that addresses the long-neglected plight of those with mental disorders. APA stands committed to the goals that the President has set and looks forward to working with Congress to shape and improve the Administration's plan.

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Principles for Mental Health and Psychological Services in Health Care Reform

Preamble

All American citizens and residents, regardless of race, national origin, income, religion, age, sex, sexual orientation, language, or geographic residence, have the right to health care and must be covered under any national health care plan.

To ensure participation of all citizens and residents, the national health care system shall: not discriminate against any individual on the basis of current health status, including any coverage exclusion or limitation based on a pre-existing condition; base the cost of coverage on the concept of broadly shared risk to be determined by community-wide rating; and ensure that health care coverage is portable and continuous.

Fundamental reform of the health care system includes:

- Access to health care for all;
- Appropriate and fair cost containment;
- Improved quality of care;
- Comprehensive health benefits, including mental health benefits for all people experiencing mental disorders and psychological services for the diagnosis, prevention, and treatment of certain medical disorders; and
- Improvement in the organization and delivery of care.

The Mental Health Benefit

People who need mental health care, regardless of age or the severity of their illness, should have access to a comprehensive array of mental health and psychological services, which emphasize treatment in the least restrictive, and culturally sensitive and age appropriate setting. Psychologists are uniquely qualified to furnish many needed services and provide a full range of preventive, acute, specialized, rehabilitative, and chronic care services.

Mental health services in a continuum of care include:

- ✓ **PREVENTIVE SERVICES**, including developmental and mental health screening and assessment and early intervention to avoid or ameliorate illness
- ✓ **EMERGENCY SERVICES**, including crisis intervention
- ✓ **OUTPATIENT AND AMBULATORY SERVICES**
 - short-term psychotherapy
 - intensive psychotherapy, particularly for people suffering serious and debilitating behavioral disorders
 - case management services
 - medication consultation
 - hospital alternatives such as day treatment and psycho-rehabilitation services
 - psychological rehabilitative services and neuropsychological services for those with mental and behavioral disorders. (For medical or neuropsychological disorders, rehabilitation and neuropsychological services should be appropriately covered as a medical or diagnostic benefit.)
- ✓ **DIAGNOSTIC TESTING AND ASSESSMENT**
- ✓ **INPATIENT AND RESIDENTIAL TREATMENT**
- ✓ **PRESCRIPTION DRUGS**
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR CHILDREN AND ADOLESCENTS**, including comprehensive and regular screening of their mental and physical health and developmental factors and school-based services
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR WOMEN**, including treatment for psychological and emotional disorders resulting from sexual or physical abuse and violence
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR PERSONS WITH HIV/AIDS**

In the absence of a comprehensive Federally-mandated mental health benefit, Federal national health reform legislation should not pre-empt state initiatives to ensure the provision of benefits for persons needing mental health treatment.

Reform of the Mental Health Delivery System

Equity

The provision of mental health services should not be limited by artificial or arbitrary numbers of visits, days, or financial caps. Duration and scope of services should be based on medical or psychological necessity in accordance with professional standards of reasonable care. Individuals requiring mental health treatment and their families should not need to spend a disproportionate share of their income and resources to obtain services.

Efficiency

Appropriate, high quality mental health care should be delivered in the most cost-effective manner. The present mental health delivery system wastes resources, leaving those most in need without adequate care. Resources need to be more appropriately allocated to encourage the use of cost-effective forms of treatment and to ensure access to a broad array of integrated outpatient and inpatient mental health services for all who require care. A reformed mental health system under any national health plan must incorporate the following tenets:

- ⊕ People with serious mental illness should be treated through a more properly designed mental health benefit, which incorporates adequately funded long-term care services.
- ⊕ Outpatient mental health treatment, compared with inpatient treatment, is relatively cost-effective and as efficacious in many treatment areas, and studies have demonstrated that the use of copayments sufficiently controls the demand for utilization of outpatient mental health services without the need to resort to arbitrary limits. Copayments should be scaled to income or subsidized in a manner to avoid undue financial hardship on individuals seeking treatment.
- ⊕ For inpatient treatment, copayments and other cost-sharing will ensure greater individual responsibility for treatment cost. Appropriate case management with preadmission review by a financially disinterested entity or professional will help reduce unnecessary inpatient costs.

Quality

To eliminate the serious quality of care problems that managed care programs have created for patients needing mental health services, service delivery entities should be required to adhere to standards which protect the patient, including:

- ⊕ separating clinical review from financial interest
- ⊕ ensuring the provision of an adequate range of high quality, individualized services
- ⊕ maintaining liability for negligent cost-containment mechanisms and review determinations
- ⊕ ensuring confidentiality of Patient-Provider information
- ⊕ maximizing patient choice
- ⊕ making public the review standards and criteria used in evaluating care plans
- ⊕ using reviewers who are licensed or certified in the areas of mental health care under review
- ⊕ limiting review frequency and amount of information requested
- ⊕ ensuring that decisions are quickly made
- ⊕ establishing arbitration or similar hearing arrangements to resolve appeals.

A national plan must include these minimum standards for managed care. Federal legislation should not pre-empt existing state statutes which protect patients from current managed care abuses.

Access to Psychological Services

Health and behavioral services are cost-effective and efficacious. Consumer participation should be encouraged in treatment planning decisions, including the selection of services, settings, and providers. State provider freedom of choice laws should be protected and expanded to apply to managed care entities.

To meet the needs of all Americans, particularly those in rural and underserved areas, national health care reform should promote the training of psychologists and other mental health providers. Linkages between psychologists and primary care providers should be encouraged.

The reformed mental health care system should promote the public mental health system's role of providing services for those individuals who might not otherwise receive mental health care. States should be encouraged to provide an array of mental health and rehabilitation services, and general health, mental health, and social services should be integrated, particularly for the severely mentally ill. Public systems should be afforded the opportunity and be encouraged to compete with private plans formed under the national system to offer specialized or comprehensive mental health and rehabilitative services.

Research

National health reform should be committed to comprehensive mental health research with increased behavioral science, health psychology and psychological treatments studies. Mental health research serves as a foundation for ongoing improvement in the detection, treatment and prevention of psychological disorders and in the definition of the psychological and neuropsychological components of conditions with physical etiology.

Many of the leading health problems which most seriously impact our nation's workforce, including alcohol abuse, drug abuse, depression, stress, mental health problems and cigarette smoking, have a psychological or behavioral component. Psychology and particularly health psychology initiatives should be integrated into mainstream health and medicine as key treatments and interventions to combat these crippling and costly problems.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Chairman Kennedy, Senator Wellstone, Members of the Committee:

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit testimony to the Senate Committee on Labor and Human Resources to share our views on the proposed mental health care benefit package in President Clinton's health care reform plan.

The AOTA, established in 1917, represents the professional interests of 47,000 occupational therapists, occupational therapy assistants and students of occupational therapy. As health and rehabilitation professionals, our members provide services to those disabled by illness, injury or psychological or developmental impairment. A registered occupational therapist or a certified occupational therapy assistant (COTA) must be a graduate of an educational program accredited jointly by the American Medical Association and the American Occupational Therapy Association, complete supervised field work and pass a national certification examination. Course work for both therapists and assistants includes the biological sciences and psychosocial development.

The profession of occupational therapy has its roots in the field of mental health. Occupational therapists help individuals with mental health disorders to develop the skills necessary for independent, productive living. Particular emphasis is given to assisting the individual in the transition from hospital to the community and in teaching adaptive skills and coping strategies to help prevent rehospitalization. Occupational therapists provide services in acute psychiatric admission units in general hospitals, private psychiatric hospitals, state psychiatric hospitals, Veterans Administration medical centers, and crisis centers. Included among the community-based mental health care settings where occupational therapists are employed or provide consultation are partial hospitalization and day treatment programs as part of outpatient psychiatric clinics, community psychiatric rehabilitation programs (also known as psychosocial rehabilitation programs), community mental health centers, home health agencies, nursing homes, and group and private homes.

We believe the President deserves great credit for making reform of the nation's health care system a centerpiece of his legislative agenda and for advancing a comprehensive proposal to achieve that goal. We applaud the Administration's efforts to provide universal insurance coverage for a comprehensive range of health benefits. We support the recommendations for insurance industry reform, which would eliminate highly discriminatory practices such as pre-existing condition exclusions, a critically important reform for individuals and families who experience chronic conditions and disabilities. The new initiatives in long term care services and supports for those with severe disabilities are major steps toward addressing the needs of some of the most vulnerable members of our society.

The President's initiative presents the opportunity to reform our health care system in a comprehensive manner to improve the availability of health care to all Americans. Comprehensive reform can enable us to examine health care with a wide lens, encompassing a view of health which addresses the needs of an individual to lead a full and productive life. It offers the opportunity to solidify gains made possible by new knowledge, and to refine and redirect trends such as managed care to better meet the health care needs of Americans. Our goals in health reform must look to larger issues: to more effectively and productively use our human and financial resources, to enhance each individual's contribution to our society, and to maintain the quality and innovativeness of health care in America. In many respects the president's proposal holds great promise to meet these challenges. However, a comprehensive revamping of health financing and delivery brings with it the potential for unintended consequences and adverse effects.

AOTA believes the President's proposal does not sufficiently meet the needs of individuals with mental illness because it incorporates benefit limits that do not mirror the treatment accorded physical illness under the plan. The benefit structure applies stringent limits on alternatives to inpatient care, particularly limiting intensive non-residential treatment, as well as restricts who can receive mental health care. We are concerned that the mental health benefit of the President's plan undermines a growing effort in our nation to treat individuals with mental health care needs appropriately and to take their needs seriously. Waiting until the year 2001 to provide mental health care on par with physical health care interrupts an emerging comprehensive and flexible system of mental health care where the individual is served in the least restrictive, often more appropriate and less costly, alternative to traditional inpatient care. Implementation of an antiquated system of arbitrary limits on mental health care during this interim period is, indeed, a step backwards from this changing system, and serves to perpetuate inaccurate assumptions and stigmatization toward mental health problems.

AOTA supports the position of the Mental Health Liaison Group (MHLG) as presented in their testimony submitted to the Committee regarding defects of the interim benefit plan as well as other shortcomings in the mental health benefit. It is ironic that the President's plan represents a mental health benefit package that is less than the average plan now offered by many health insurance plans. We would specifically like to address our comments to the seriousness of short-changing the availability of alternative services to inpatient care, and to the importance and cost effectiveness of providing a full range of services.

THE BENEFIT MUST INDIVIDUALIZE CARE AND CONTINUE ALTERNATIVES

Over the past 20 years, the range of intensive nonresidential services - partial hospitalization, day treatment, psychiatric rehabilitation, community mental health care programs, home-based care, etc. - have become an integral part of our nation's mental health care system. Alternatives to inpatient care emerged primarily for three reasons: as part of a movement to find more effective alternatives to inpatient acute and residential care, as a means to control high utilization rates of emergency rooms and repeated hospitalizations, and in response to low functioning capabilities of individual with mental illness. These services are now recognized as an important component of the mental health care delivery system as both more appropriate alternatives to inpatient care and as transition services for a hospitalized patient. Stephen White, vice president of Charter Medical Corp. in recognizing that hospitalization may not longer be the only appropriate treatment, says that "(p)sychiatric care should be matched to the specific needs of each patient,...and recognize that a comprehensive mental health provider has to offer an array of services..." (Special Report, Business and Health, "Psychiatric Care Delivery is Improving").

An important part, and in some cases, the most important part, of an individual's mental health care treatment is help with coping and functioning in society. Pharmacological treatment alone is not sufficient. Occupational therapists work with behaviors that interfere with an individuals functional independence. Without this assistance, individuals often inappropriately end up back in the hospital. The National Institute of Mental Health (NIMH) reports much lower recidivism rates when a combined set of outpatient services are provided to the individual (Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council, Rockville, Maryland: National Institute of Mental Health, 1993).

Intensive non-residential services are designed specifically to help the individual with a mental illness learn to manage the symptoms of the illness in a normal setting. One of the cognitive disabilities often seen in an individual with a severe mental illness is difficulty in generalizing learning from one situation to another. The functional limitations frequently seen in an individual with a mental illness may include deficits in daily living, impaired social interactions, ineffective problem solving, a diminished ability to maintain relationships, and a marked impairment in role functioning. Assessment and

interventions provided by an occupational therapist in these settings address the underlying factors (performance components) that contribute to or interfere with desired functional outcomes in the areas of sensory motor skills, cognitive skills and psychosocial skills. For example, in a hospital, an individual with schizophrenia may have learned the skills necessary to cook independently but may be unable to adapt the information learned to his living environment.

As the Mental Health Liaison Group reported in their testimony, despite the fact that intensive non-residential care has become an important component of mental health care in rehabilitating individuals with serious mental illness, the President's health care plan makes the first 60 days of these services available in the interim plan only as a trade off to inpatient care. Consequently individuals are forced to relinquish their inpatient safety net to utilize community-based intensive care. This places an undue burden on the individual and actually gives the individual no real choice at all to choose clinically appropriate care.

To use the second sixty days, an individual must pay both a one-day deductible and 50% copayment. Even in the low copay plans, using the 60 days will cost the individual \$1500, none of which counts toward the out-of-pocket limit.

As the MHLG reports, the combination of trade-offs and high co-payment requirements negates the value of this innovative approach as an alternative to high cost inpatient care as a means of serving the individual in the least restrictive environment. AOTA joins the MHLG in urging the restoration of intensive nonresidential care to an independent benefit, not requiring a trade-off or oppressive copayments.

CLINICAL AND COST-EFFECTIVENESS OF ALTERNATIVE CARE RECOGNIZED

The NIMH research reveals that most mental disorders can be appropriately treated without hospitalization. Intensive non-residential care such as partial hospitalization and psychiatric rehabilitation has significantly reduced hospitalization and improved an individual's level of functioning and quality of life. NIMH reports on studies that show these treatments have been successful with patients with manic depression, schizophrenia, and anxiety disorders (NIMH, 1993).

Evidence of these successes is the fact that both self-insured health care plans and private psychiatric hospitals have changed their mental health benefits plan to offer alternatives to inpatient care. A review of the private psychiatric hospitals who are members of the National Association of Psychiatric Health Systems (NAPHS) demonstrates these changes in the mental health care delivery system. The number of NAPHS psychiatric hospitals offering alternatives to inpatient care have steadily increased and the number of new patients entering partial care programs jumped from approximately 172,000 in 1980 to 293,000 in 1988. Data from a 1992 survey on the past three-years of activities of these hospitals showed 79% of the private psychiatric hospitals offered occupational therapy services as part of their care (Special Report, Business and Health).

Outcomes research collected by the International Association of Psychosocial Rehabilitation Services (IAPRS) includes a review of 35 studies by Dion and Anthony (1987) showing that psychiatric rehabilitation interventions reduced hospital recidivism and positively affected employment, skill development, client satisfaction, and the amount of time spent in the community. Additionally, they found many studies showing the reduction of hospital utilization as a result of psychiatric rehabilitation and case management services (Bond et. al, 1984; Bond, 1988; Dincin and Witheridge, 1982; Fairweather and Fergus, 1988; Hammaker, 1983).

In addition to clinical effectiveness, IAPRS also reviewed studies regarding the cost effectiveness of alternative care. Cost savings were evident by lower hospitalization rates, reduced utilization of community treatment by the individual over time, and increased employment. In studies regarding schizophrenia, Goldberg (1991) found community care was more cost effective than hospital care.

Mental health care is relatively inexpensive compared to other health care services. Mental health care costs have remained relatively constant over the past 15 years, making up approximately 10% of total health care treatment (NIMH, 1993). The cost to society of not providing an adequate mental health benefit will be much higher in unemployment, welfare, homelessness, etc. Individuals with untreated mental illness consume almost twice as much medical care as the average individual. (Borus, et. al., 1985.)

MANAGED CARE

The mental health community has had experience with both good and bad managed care practices. AOTA supports good managed care practices as an alternative to arbitrary and discriminatory limits on mental health care. A 1992 Hay/Huggins (a Washington-based actuarial firm) report on psychiatric benefits, managed care organizations have claimed savings between 15% and 40% due to alternative care, compared with traditional approaches (Special Report, *Business and Health*). Strong quality assurance mechanisms, developed by a comprehensive range of health professionals, as well as strong grievance procedures, is critical to ensuring quality care while attempting to contain costs.

AOTA has endorsed the managed care safeguards articulated by the Consortium for Citizens with Disabilities (CCD) Health Task Force, a copy of which is attached for the Committee's review. Specifically, these recommendations address problems such as financial incentives used to restrict access, the lack of an array of comprehensive services needed, the lack of quality assurance mechanisms and effective grievance policies to ensure access to appropriate care; and the lack of expertise and training on the part of gatekeepers to determine the needs of individuals, particularly the specialized mental health and disability needs of individuals, and access to specialists and specialty care.

Creating a gatekeeping process that can ensure individuals have access to appropriate care, whether it be mental health or other specialty care, must recognize a single gatekeeper's limited expertise in these specialty areas. Managed care plans should not be permitted to arbitrarily select one health discipline to be the gatekeeper for all individuals, and in effect, control and possibly limit the range of services available. Information of health and mental health needs of individuals, as well as information on current and appropriate practices, must be sought from a variety of sources, including the health professional whose service is under review. A multidisciplinary team approach can be required where a combination of opinions are solicited, including the opinion of a specialist licensed and trained specifically to provide the service being evaluated.

AOTA hopes that the Committee and the Senate will support a comprehensive system of mental health care subject to the same cost containment strategies as physical health care. We urge you to consider the research base which supports the need and cost effectiveness of intensive non-residential care, particularly as appropriate alternatives to inpatient care.

We look forward to working with you to develop a responsible mental health care plan for health care reform.

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

PROBLEMS AND SAFEGUARDS FOR PEOPLE WITH DISABILITIES IN MANAGED CARE

The CCD Health Task Force "Principles for Health Care Reform from a Disability Perspective" were developed to assess the ability of various major health care reform measures to meet the needs of people with disabilities. Since many reform proposals utilize some form of managed care, the CCD has applied these principles and identified a number of major problems in managed care systems.

This document identifies these problems and makes recommendations to improve the ability of managed care systems to better meet the needs of people with disabilities. The CCD believes that it is critical for health care policy makers to recognize that there are at least 43 million Americans with disabilities and a large number of others with special health care needs. This includes individuals of all ages with physical and mental impairments, conditions or disorders, that are severe, acute, or chronic and limit or impede their ability to function.

Problems with Recommendations for Improvement

- I. Managed care systems often include financial incentives to restrict access, limit or deny care, or provide poor quality care. This is especially detrimental to children and adults with disabilities and those with special health care needs.
 - A. Capitated managed care systems must have the flexibility necessary to permit primary care physicians to refer participants with disabilities to specialists without being financially penalized.
 - B. Primary care physicians in managed care plans must be adequately compensated and not placed at inordinate financial risk.
 - C. Methods for ensuring the financial solvency of managed care entities, particularly capitation models, must be considered. These may include financial solvency requirements for HMOs, mandatory reinsurance, state reinsurance for Medicaid managed care programs, stop-loss coverage, and mandatory capitalization requirements.
- II. Managed care systems often do not include the array of comprehensive health related services needed by children and adults with disabilities.
 - A. Managed care programs must offer a comprehensive benefits package that meets the needs of people with disabilities and special health care needs. This includes such basic benefits as prescription drugs, rehabilitation services, durable medical equipment, such as wheelchairs and other assistive technology, and mental health services.
 - B. Managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.
 - C. Specific services should be provided not only to treat acute and chronic conditions but also to promote and maintain health and optimum functioning and prevent deterioration and secondary complications.
- III. Managed care systems often have limited experience in providing comprehensive services to children and adults with disabilities because of a systemic emphasis on primary care. This leads to limited access to needed specialized services, delays in services, and a lack of continuity of care needed by children and adults with disabilities.
 - A. Managed care systems must offer people with disabilities and special health care needs the option of having a specialist as their "gatekeeper" in the system. This specialist would provide both necessary specialized care (at the specialized rate) and primary care (at the lower primary care reimbursement rate).
 - B. Managed care entities must have specific limits on waiting times for first appointments and for specialty referrals. To assure geographic accessibility of services, there must also be established standards on travel times and distances to both primary and specialized services.
 - C. Managed care systems must be structured to ensure continued, appropriate access to health and health-related services for children and adults with disabilities.
- IV. Managed care systems lack adequate quality assurance mechanisms, as well as effective grievance policies and procedures designed to ensure access to appropriate health services.
 - A. Managed care systems must provide participants with clear information on policies, procedures, and grievance mechanisms and must ensure consumer participation in the establishment of such procedures. All reviews must be conducted in a timely manner. An independent ombudsman program should be required.
 - B. Managed care systems should be required to provide health care service in accordance with nationally accepted prevention and treatment protocols, e.g. protocols for prenatal care, well-baby care, and childhood immunization schedules.
 - C. Managed care systems must have in place timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary" or when a consumer challenges the appropriateness of a proposed treatment. These second opinions must be considered in any grievance review.
 - D. Managed care systems must include the option to disenroll for those participants who are not receiving adequate and timely services.
 - E. Managed care programs must have strict quality assurance provisions that require internal and external audits by independent assessors and the results of these audits should be available to consumers to assist them in choosing a managed care program. Outcome reviews should be a component of this process.
 - F. Additional protections which must be included are satisfaction surveys of enrollees and disenrollees, including current and former providers.

For additional information contact: Co-Chairs of the CCD Health Task Force
 Bob Gries, United Cerebral Palsy Association, (202) 842-1266; Kathy McGinley, The Arc, (202) 785-3388; Jane O'Keefe, American Psychological Association, (202) 336-5934; Bill Schmidt, Epilepsy Foundation of America (301) 459-3700; Steve White, American Speech, Language, and Hearing Association, (301) 897-5700.

Testimony to the
Committee on Labor & Human Resources
U.S. Senate
on the Mental Health Provisions in the
Health Security Act of 1993
November 23, 1993

Submitted by:

- American Academy of Child and Adolescent Psychiatry
- American Association for Marriage and Family Therapy
- American Association for Partial Hospitalization
- American Association of Children's Residential Centers
- American Association of Pastoral Counselors
- American Association of Psychiatric Services for Children
- American Counseling Association
- American Family Foundation
- American Occupational Therapy Association
- American Psychiatric Association
- American Psychoanalytic Association
- American Psychological Association
- American Society for Adolescent Psychiatry
- Anxiety Disorders Association of America
- Bazelon Center for Mental Health Law
- Child Welfare League of America
- Cult Awareness Network
- Family Service America, Inc.
- Federation of Families for Children's Mental Health
- International Association of Psychosocial Rehabilitation Services
- National Association of Counties
- National Association of Homes and Services for Children
- National Association of Psychiatric Treatment for Children
- National Association of Protection and Advocacy Systems
- National Association of Social Workers
- National Association of State Mental Health Program Directors
- National Community Mental Health Care Council
- National Depressive and Manic Depressive Association
- National Federation of Societies for Clinical Social Work
- National Foundation for Depressive Illness
- National Mental Health Association
- National Organization of State Associations for Children
- Society for Education & Research in Psychiatric-Mental Health Nursing

Chairman Kennedy, Senator Wellstone, Members of the Committee:

The undersigned mental health organizations are pleased to present our views on mental health provisions in the Health Security Act. Thank you for making our views part of the record of the hearing you held on November 8.

The hearing permits us to examine the mounting evidence that mental health benefits are a sound investment in the healthcare of our nation and to correct erroneous notions about the cost and effectiveness of mental health treatment. It also provides us the opportunity to evaluate the plan presented by President Clinton on November 20 from the viewpoint of people who need mental health services.

We commend the President and Hillary Rodham Clinton for their leadership in bringing healthcare reform to the fore. And we want particularly to acknowledge the valiant efforts of Tipper Gore, who headed the work group on mental health and has been an ardent and eloquent champion of mental health services from the beginning.

Our Position on Mental Health Benefits in Health Care Reform Legislation

Our position is clear and explicit: mental health care must be an integral part of healthcare reform. Some of us may emphasize one element of the overall benefit and some another, according to the needs of our particular constituencies. But we stand united behind the following principle: Mental health benefits must be provided through a system of organized care, with a full continuum of services, and must not be subject to arbitrary limits in amount or duration of services which are not imposed on other healthcare benefits. The position has found significant support in Congress. Over 218 members of the House and 18 Senators have endorsed concurrent resolutions calling for parity and the inclusion of a comprehensive mental health benefit within any healthcare reform initiative.

Without a comprehensive flexible array of mental health services, the basic benefits package will neither serve the essential needs of the population nor be cost effective. We ask you to soundly reject the spurious reasoning that argues against comprehensive mental health coverage. Much of it is based on conditions which no longer exist and assumptions that are badly outdated. This coverage is far too important to our nation and to the millions of people who suffer from mental disorders to allow it to be buried under the dust of antiquity.

The Positive Elements in the Health Security Act of 1993

The Clinton plan has many broad features that are clearly in the best interests of the general public as well as people with mental disorders. Most importantly, it assures universal coverage to all lawful residents regardless of income and job status. In disproportionate numbers people with serious mental illnesses now are without health coverage at all because they are not in the work force.

Further, the proposal eliminates annual and lifetime dollar limits on healthcare services, abolishes pre-existing condition exclusions, includes coverage for assessment, diagnosis and crisis intervention, creates

a new community-based long-term care program, and stresses prevention and early intervention. These aspects of the plan are tremendously important to our constituencies. We also recognize the significant value of the overall benefits package to the populations for which we advocate. After all, individuals with mental illnesses get other illnesses too.

The Administration's proposal makes mental health services an integral part of the basic benefits package. It clearly articulates the principle of parity between the treatment of mental illness and other illnesses by committing to full comprehensive benefits without arbitrary limits on January 1, 2001, three years after the onset of the program. However, until full equity is achieved, the interim mental health benefits in the plan contain severe limits on amount and duration and excessive copayments which substantially interfere with their accessibility by people with mental illness. Eligibility for mental health services should be determined on the basis of medical or psychological necessity, not by overly restrictive criteria like life endangerment. We discuss the problems with the interim benefit in more detail below.

Our Objectives for Healthcare Reform

As the deliberations around healthcare reform unfold, there are key objectives our organizations and the people they represent want Congress to pursue:

- ◆ Congress should endorse and enact the Administration's commitment to full coverage for mental health services to begin on the date of initial implementation of the plan rather than in 2001.
- ◆ Congress should remove the discriminatory barriers to access for low-income people with mental disorders caused by copayments and inadequate subsidies.
- ◆ Congress should add incentives to assist the integration of public and private mental health providers to end the two-tier system of care prevailing today.
- ◆ Congress should assure that each health plan permits maximum consumer choice in provider selection and participation in treatment planning, confidentiality of records and due process procedures.
- ◆ Congress should require that quality assurance standards and access to services are supported by monitoring mechanisms to assure that consumers receive the amount and level of care they need.

Why Equity Now

The Clinton plan for health care reform contains a firm unequivocal commitment to comprehensive mental health services in 2001, three years after the effective date for implementing the Act. The date is not dependent on any other factor such as approval of the state plan for integrating mental health services or cost savings in the interim period. We appreciate the Administration's commitment to eventual equity. However, we urge equal treatment for mental and physical disorders when the overall program goes into effect in 1998. We agree with Senator Wellstone, who reminded us in his Roll Call article that "those in need cannot wait until 2001 for the phase-in."¹

There are compelling public policy reasons for making comprehensive benefits available from the start rather than 2001. The absence of a comprehensive benefit will perpetuate unnecessary national costs

for mental illness, both within and outside the health care system. Coverage for a full continuum of mental health services is essential to ensuring access to care in the most appropriate and cost-effective setting. Until the phase-in occurs, care will be limited by the services covered rather than the services the patient needs. The imbalance can inflate mental health care costs over the short term and thereby fuel the arguments of some who assert that mental health services are too expensive.

The societal payoffs of effective services for people with severe mental illness are large: increased earning power, less dependency on public programs of support, reduced pressure on the correctional system, fewer social problems. Individuals and their families can be reintegrated and their personal satisfaction enhanced. Experts even project about a 10% reduction in general health care costs, as proper mental health care will reduce use of the general health system.²

The three year period between enactment of the plan in 1994 and implementation in 1998 is sufficient time for providers to develop the management capacity and procedures to properly administer a comprehensive plan. Artificial limits on care are not only costly to the consumer but unnecessary as well. The limits create disincentives to move toward a truly flexible comprehensive benefit in 2001.

Finally, we are fearful that 2001 may never arrive for those suffering from mental disorders if full implementation is delayed. The goal may be made hostage to the achievement of cost savings or other considerations that could excuse the Administration and Congress from the promise of equitable coverage.

Deficiencies in the Plan for People with Mental Illness

The President's interim plan for mental health services raises a number of serious problems for people with mental illness which demonstrate why a limited benefit is unworkable. We have divided our concerns into two sections, the first relates to the mental health benefit provisions; the second, to problems in other parts of the bill which have serious consequences for people with mental illness.

A. Defects in the Interim Mental Health Benefit

1. Limitations on Inpatient/Residential Services

The plan permits extension of inpatient/residential services beyond 30 days only on the basis that the patient is a threat to himself or others, needs drug regimen adjustment or requires somatic therapy. These limited bases represent interference with the patient's ability to obtain necessary and appropriate treatment. Medical and psychological necessity should be the criteria for determining length of stay. The trade-off features in the benefit compound the problem. For example, after drawing down 30 inpatient days to use the first 60 days of the intensive nonresidential benefit, individuals may find they have "lost" access to the inpatient benefit because of the overly strict criteria for obtaining additional days.

2. Restrictions in Intensive Non-residential Treatment

The intensive non-residential benefit offers a bold and progressive approach to treating people with serious mental illness. However, it contains conditions which make the service difficult to access. The initial 60-days are available only on the basis of trade-offs for inpatient care. This arrangement forces individuals

whose illnesses are often unpredictable to relinquish their inpatient safety net to utilize community based intensive services. The choice places an inappropriate decision burden on people with mental illness. Their conclusion is likely to be based on fear rather than clinical appropriateness.

To use the second sixty days, an individual must pay both a one-day deductible and 50% copayment. Even in the low-copay plans, using the 60 days will cost the individual \$1500, none of which counts toward the out-of-pocket limit on the individuals total health expenditures.

Further, the four "treatment purposes" in the bill are in conflict with language immediately preceding them that permits the health plan "based on criteria that the plan may choose to employ" to determine that the individual should receive intensive non-residential treatment.

The combination of trade-offs and high co-payment requirements diminishes the value of this innovative approach as an alternative to more expensive inpatient care. Only if these services are fully available will consumers have a true choice to utilize the least restrictive environment.

3. Confusion on Psychotherapy Substitution

The bill attempts to offset a totally inadequate 30-visit benefit with a provision that allows health plans the discretion to substitute four outpatient psychotherapy visits for one day of hospital care to reduce or shorten hospitalization. It is unclear whether the plan's discretion applies to determining the individual situations where the substitution is applicable or the availability of substitution entirely. If the latter, the provision can create serious adverse selection problems, as discussed below. Patients who reach maximum limits on outpatient psychotherapy (as with other limited services in the bill) are faced with the same difficult and, in some cases, life threatening situation: no coverage for needed services. Unlike any other health benefit, individuals suffering from a mental disorder are forced to accept arbitrary and discriminatory limits on care vital to their recovery.

4. Inadequate Incentives to Integrate Public and Private Systems

At the present time, there are two tiers of mental health services: the publicly funded state system which serves as a safety net for the most seriously ill; and the private system which relies on multiple funding sources, including a significant percentage of private pay patients. Together with the President, we support the integration of these two systems. Under an integrated approach, the role of the public system undoubtedly will change--probably by moving away from acute service delivery toward emphasis on support services, quality assurance and innovation. Congress should assist the process by creating incentives for states to integrate their system with the national plan while protecting those vulnerable populations who will be at risk if state mental health service dollars are diverted into other purposes. In addition, we recommend that Congress authorize the states, applying Federal standards, to designate publicly supported mental health and substance abuse programs as *essential community providers* to ensure that people in low income areas will have access to services and promote the integration of the public and private systems.

5. Cut-back on Collateral Services

The latest revision to the plan reduces the mental health benefit by including collateral services for family members within the already inadequate 30-visit limit on psychotherapy. In the October 27 draft bill, 30 visits for collateral services were in addition to psychotherapy. Visits with family members are often highly effective means for treating the individual with mental illness.

6. Barriers to Services for Children

The interim benefit creates barriers and disincentives to services for children. The requirement that the individual pose a threat to himself or others to receive residential treatment beyond 30 days is wholly inappropriate for children. Similarly, having to substitute home-based, behavioral aide or day treatment services for residential care will leave parents with seriously ill youngsters with fewer future choices. They may forego effective community treatment in order not to lose their residential safety net. The high copayments may be a particular barrier for children who are dependent on others to gain access to needed treatment.

Instead of building barriers and disincentives, public policy should actively encourage early identification and intervention for childhood problems. The Clinton plan endorses this approach for conditions other than mental illness. The failure to do so for our children only results in devastated young lives and higher future costs as untreated problems worsen into disability.

7. Inappropriate Services for People with Dual Diagnoses

People with substance abuse disorders and mental illness are particularly at risk of undertreatment because the limits on services apply to both conditions. The needs of a dually diagnosed individual may quickly exceed the limits in the interim benefits package. The effect will be that people with substance abuse disorders and mental illness will be forced to obtain care in the overburdened public system much sooner than others not so seriously impaired. We recommend that Congress recognize the special situation of the dually diagnosed population. Only a comprehensive benefit would accurately responds to their needs.

B. Other Weaknesses of Particular Concern to People with Mental Illness

1. Caps on Premium Subsidy

The plan contains premium subsidies to low income individuals and small businesses. If the subsidies required in a given year exceed the estimates for the year, an additional appropriation is needed. We believe the failure to make the subsidy payments automatic potentially threatens guaranteed access to care. If Congress fails to enact additional revenues, the plans can pare back benefits. Given the historic stigma associated with mental illness and substance abuse, we fear these benefits will be cut first when shortfalls occur. We recommend that the legislation contain guarantees that no one can be denied any benefit under the plan because of insufficient funds for subsidies.

2. Unaffordability of Services

The poorest and the sickest among us become even more vulnerable when access to care is contingent on payment of deductibles and coinsurance. For many Americans living in the shadows of economic despair even the most minimal copayment can be prohibitive. We believe that individual responsibility is a valuable principle, but it should not become a mantra invoked to legitimize continued discrimination against low-income citizens, regardless of their disability or diagnosis. Requiring 50% copayments for outpatient psychotherapy and intensive non-residential services and the one-day deductible, for example, represent excessive cost-sharing requirements which will inhibit access to critical services by people with mental illness.

We support a sliding scale for copayments to help low income people, with adequate subsidies to prevent premiums, deductibles, and coinsurance from becoming barriers to appropriate care. In addition, we believe all copayments and deductibles for mental health services should be counted toward the out-of-pocket limit, just as they are for all other benefits in the plan.

3. Inadequate Quality Standards for Delivery of Services

Individuals with chronic illness, both mental and physical, are at risk of being denied essential services in managed care settings. The experience with HMOs in limiting care to people with severe mental illness demonstrates that providers operating under capitated premiums have strong incentives to undertreat high cost patients.

Health care reform legislation should not create a culture in which clinically necessary services are inappropriately denied or are approved too late. Instead the legislation should emphasize early intervention, quality assurance standards and effective monitoring to assure that consumers receive services in the amounts and settings appropriate to their conditions.

4. Potential for Adverse Selection

We anticipate that some health plans will provide their enrollees with better mental health care either by offering four additional outpatient psychotherapy visits for one inpatient day if the additional treatment would prevent or reduce hospitalization, or by providing more effective or higher quality mental health services overall. Other plans may begin to move toward the 2001 goal of comprehensive benefits earlier. The "better" plans will naturally attract more people with mental illness. However, the Clinton proposal would penalize these plans because of the vague rules on risk adjustments for plans who have higher costs. We recommend that plans which have higher costs because of the flexibility of their benefits or the quality of their services be clearly eligible for cost adjustments.

5. Strictness of Long-Term Care Eligibility Criteria

We are pleased that the proposed eligibility criteria for the home and community-based long-term care benefit reflects an understanding of the need to use different approaches to determining eligibility for physical and mental disabilities. However, the eligibility criteria are set at a level of severity that permits only

people with extreme dysfunction of a chronic nature to receive services. The eligibility rules do not recognize the cyclical nature of the active symptoms of mental illness. We recommend that the criteria recognize that people with serious, persistent mental illness may need long-term support services on an intermittent basis.

These are serious problems areas for people with mental illness. They represent challenges to the Congress to correct the significant flaws in the Administration's plan, to enrich it and move it to the next level where true parity between mental health and physical health can be realized.

The Magnitude of the Mental Illness Problem in the United States

An enormous number of people are affected by mental health problems and will benefit from comprehensive mental health coverage. An estimated 41.4 million adults have had a mental disorder at some time in their lives³ and about 7.5 million children suffer from mental and emotional disturbances such as depression, autism and attention deficit disorder.⁴ We also know that about one-fifth of those afflicted with AIDS will develop AIDS-related cognitive dysfunction and two-thirds will develop neuropsychiatric problems.⁵ These are people who often cannot obtain mental health services under the current system. Only about one-third of the children and adolescents who need treatment ever receive it.⁶ Among adults, one out of six individuals with serious mental health problems gets needed care.⁷ And one need only look under the nearest bridge to see homeless persons with mental illness with no access to mental health services. Persons with significant mental health problems are legion within the ranks of the uninsured and the underinsured. And even those fortunate enough to have insurance coverage too often find their treatment limited by lifetime or annual limitations, discriminatory copayments, and other cost containment devices that eke financial savings out of the mental torment of the afflicted.

We cannot afford to write off so many of our people by excluding or only minimally covering mental health services in the reformed health care system. It is a matter of justice and it makes good economic sense to assure access to needed mental health treatment.

Untreated Mental Health Problems Exact a High Price

Consider for a moment the costs currently borne by society because mental health coverage is so woefully inadequate. Nearly a third of the nation's homeless persons have a severe mental illness.⁸ A majority of the 30,000 suicides in America each year can be attributed to a mental or addictive disorder.⁹ Major depression accounts for more bed days (people out of work and in bed) than any impairment except cardiovascular disorders.¹⁰ Persons with job-related stress, anxiety and depression miss an average of 16 work days per year. Persons with untreated mental illnesses consume almost twice as much medical care as the average individual.¹¹ Add to the mix the thousands of persons with mental illnesses who are denied treatment, but instead languish in high-cost prison and jail cells. Add in the costs of unfulfilled human promise, education not pursued, work not obtained, contributions to society not made. These human costs are monumental; even in hard dollars and cents, they are staggering. The costs associated with SSI, SSDI,

welfare programs, incarceration, and divorce are equally enormous--estimated at \$74.9 billion in 1990.¹² These costs are being paid every day, by people like you and me. They are being paid out in the human tragedies wreaked on families and their relatives with mental illnesses. Coverage limits so prevalent in private insurance today can shift catastrophic costs onto families, forcing many into bankruptcy or long term indebtedness. Lack of options can force persons into hospitalization, when broader coverage could permit them to be more appropriately and more cheaply treated in the community. Or worse, lack of comprehensive benefits delays needed treatment until a crisis occurs.

The Effectiveness of Mental Health Treatment

All relevant research tells us that mental health treatment is effective. A whole new armamentarium of interventions available for treatment has emerged since President Kennedy launched the community mental health movement in 1963. Medications like lithium and clozapine have worked miracles for some patients, while others have experienced dramatic success through psychotherapy, psychiatric rehabilitation programs, residential treatment, partial hospitalization, crisis intervention, day treatment, and in-home services. For most persons, the days are gone when long-term hospitalization and custodial care were the only services utilized. Today, most mental disorders can successfully be treated without hospitalization. Community based intensive treatment programs and services, such as psychiatric rehabilitation and partial hospitalization, have been shown to have a positive long term effect of significantly reducing hospital utilization, increasing the level of functioning and improving the individual's quality of life. Nearly 80% of patients with manic depression can be restored to essentially normal lives. Outpatient treatment for anxiety disorders is both effective and relatively inexpensive. Most schizophrenia symptoms can now be controlled, significantly reducing the relapse rate of patients.¹³ And companies around the nation are also discovering that relatively minimal mental health interventions can dramatically increase worker productivity and reduce absenteeism.

Mental Healthcare is a Good Investment

Mental healthcare is not as expensive nor are the costs rising as rapidly as many other sectors of health care. Three independent studies between 1971 and 1985 found that mental health costs have remained relatively constant over the last 20 years, ranging from 9-11 percent for total treatment costs.¹⁴ When combined with substance abuse treatment, mental healthcare ranks 25th in the factors influencing the increase in health care costs.¹⁵

Good mental healthcare is also a good deal because it can help reduce other physical healthcare costs. One investigator found that untreated persons with panic disorders mimicked heart patients and were often misdiagnosed and subjected to needless, ineffective, and expensive treatments.¹⁶ Other studies have shown that general inpatient medical care can be cut by as much as 70% following mental health treatment, and outpatient utilization can be lowered by 20%.¹⁷ In a study of the Federal Employees Health Benefits Plan, patients with chronic medical diseases who received psychotherapy used 56% fewer medical services

than those who did not receive psychotherapy.¹⁸ The National Institute of Mental Health has estimated that general medical costs could be reduced by as much as \$1.2 billion through the use of associated mental health treatment.¹⁹ These savings make mental healthcare a sound investment—especially when mental health services are well managed.

Managed Care and Mental Health

Managed care is an area in which the mental health community has substantial experience, both good and bad. An estimated 48 percent of people with health insurance are already enrolled in some type

We appreciate that care management is a central feature of the cost containment strategies in the healthcare reform plan. As we describe above, we are concerned that care be managed properly so that consumers receive services in amounts and settings appropriate to their conditions. We know this can be done.

Many large businesses (like Honeywell, Chevron, Pacific Bell, and IBM) now know that managed care techniques are as effective—and often more effective—than the imposition of arbitrary and discriminatory limits on mental health care. For example, McDonnell Douglas Helicopter Company realized a decline in per capita costs of 34% under a managed mental health benefit, including a 50% reduction in psychiatric inpatient costs. First National Bank of Chicago removed its mental health coverage limits and also reduced inpatient costs by 50% over five years under a managed care approach.²¹ We believe the Congress should take notice of such experiences and build upon their successes by removing all discriminatory barriers to mental health services once and for all.

Seize the Moment Before It Passes

Skeptics might question whether it is feasible to improve upon the President's benefit package at a time when cost considerations are so prominent. But we assert that it is not only feasible, it is also prudent. The availability of a broad array of community based mental health services can produce the offset in costs indicated by research. The sooner these services become fully available, the sooner the savings will be realized. Major businesses have achieved significant offsets and savings by eliminating discriminatory features in the plan design and permitting the mental health benefit to be managed on the basis of medical necessity. Their experience should weigh heavily in your judgments, because it reflects a broader reality than a narrow technical perspective dominated by arcane rules for "scoring" savings. The offsets demonstrated through research and real-world application have greater validity than conjectural and abstract mathematical calculations.

The time to fix flaws and address known problems is now. With the Senate Working Group on Mental Health/Mental Illness and its House counterpart, and the members of this Committee, the mental health community is fortunate indeed. We look forward to working closely with all of you and your colleagues in helping to shape the mental health benefit to serve the needs of our people.

¹Wellstone, P., "Mental Health Care is a Right for All, Too: But Clinton Plan Relies Too Much on Inpatient Treatment, May Make Cost Too High to Afford," Roll Call Health Care Reform Policy Briefing, October 18, 1993.

²See p.12, *infra*, fn 16-19. For example, Strain, J.J., Lyons, J. S. and J.S. Hammer, "Cost Offsets from a Psychiatric Consultation-Liaison Intervention with Elderly Hip Fracture Patients," *American Journal of Psychiatry*, Vol. 148 (8) August 1991.

³Bourbon, K. H.; Rae, S.; Locke, Z.; Narrow, E.; and Regier, D., "Estimating the Prevalence of Mental Disorders in U.S. Adults from the Epidemiologic Catchment Area Survey," *Public Health Reports*, Vol. 107, No. 6, November-December, 1992.

⁴U.S. Congress, Office of Technology Assessment. *Children's Mental Health: Problems and Services--Background Paper*, OTA-BP-H-33 (Washington, DC: U.S. Government Printing Office, December, 1986).

⁵Detmer, W.M. and F.G. Lu, "Neuropsychiatric Complications of AIDS: A Literature Review," *Intl. Psychiatry in Medicine*, Vol. 16 (1) 1986.

⁶U.S. Congress, Office of Technology Assessment, *op. cit.*

⁷Manderscheid, R. et al., "Congruence of Service Utilization Estimates from the Epidemiologic Catchment Area Project and Other Sources," *Arch of Gen. Psychiatry*, Vol. 50 February, 1993.

⁸Interagency Council on the Homeless, *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness*, (ADM) 92-1904, Washington, DC: 1992.

⁹National Center for Health Statistics, Public Health Services, U.S. Dept. of Health and Human Services 1993. Unpublished data from Division of Vital Statistics.

¹⁰National Advisory Mental Health Council, *Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council*, Rockville, Maryland: National Institute of Mental Health, 1993.

¹¹Borus, J.F., Olendski, M.C., et al., "The Offset Effect' of Mental Health Treatment on Ambulatory Medical Care Utilization and Charges," *Archives of General Psychiatry*, Vol. 42, June, 1985.

¹²National Advisory Mental Health Council, *op. cit.*

¹³*Ibid.*

¹⁴*Ibid.* See also, Rice, D.P., Kelman, S., Miller, L.S., et al., *Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*, DHHS Pub. No. (ADM) 90-1694, Rockville, Maryland, ADAMHA, 1990; Harwood, H.J. and Napolitano, D.M., et al., *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness: 1980*, Research Triangle Park, North Carolina, Research Triangle Institute, 1984; and Cruze, A.M., et al., *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness, 1977*, Rockville, Maryland, ADAMHA, 1981.

¹⁵Modern Health Care's compendium of Cost Factors; Coddington.

¹⁶National Institute of Mental Health, Memorandum from Alan Leshner, Deputy Director, Concerning cost-effectiveness of mental health services, Rockville, Maryland, 1993

¹⁷Mumford, E., and H.I. Schlesinger, et al. "A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment," *American Journal of Psychiatry*, Vol. 141 (10) October, 1984.

¹⁸Schlesinger, H.J., Mumford, E., Glass, G.V., et al., "Mental Health Treatment and Medical Care Utilization in a Fee-For-Service System: Outpatient Mental Health Treatment Following the Onset of a Chronic Disease," *American Journal of Public Health*, Vol. 73 (8) April, 1993.

¹⁹National Advisory Mental Health Council, *op. cit.*

²⁰McDonnell Douglas Corporation. *McDonnell Douglas Corporation Employee Assistance Program Financial Offset Study: 1985-1989*, St. Louis, MO: McDonnell Douglas Corporation and Alexander Consulting Group, 1990; Washington Business Group on Health.

The Hon. Paul Wellstone, Chairman
 Working Group on Mental Health and Substance Abuse Benefits
 Labor and Human Resources Committee
 United State Senate - SD 428
 Washington, DC 20510

Dear Sen. Wellstone:

RE: Health Security Act of 1974/Testimony for Public Record

"an ounce of prevention is worth a pound of cure"
 ----Benjamin Franklin

The above adage is all too true and succinctly characterizes the value of alcohol and other drug abuse treatment services in reducing the high cost of health care in this country.

Numerous studies and extensive research in the field have consistently reached the same conclusion: Treatment Works! and millions of dollars in annual health care costs can be saved through prevention and treatment of alcohol and other drug abuse. Therefore, it is imperative that any health care program include benefits for alcohol and other drug abuse treatment services.

The County Alcohol and Drug Program Administrators Association of California, Inc. (CADPAAC) has reviewed the latest revision of the proposed Health Security Act and respectfully submits the following recommendations and comments:

1. MAINTAIN THE ALCOHOL AND DRUG TREATMENT BENEFIT WITHIN THE HEALTH SECURITY ACT.

While this country has been waging a "War on Drugs", the vast human tragedy created by alcohol and other drug problems has yet to be effectively addressed. Universal coverage for effective alcohol and other drug abuse treatment is absolutely essential. The treatment of alcohol and other drug abuse as a primary disorder has been determined to significantly offset other health care costs as well as costs associated with the criminal justice, social services and educational systems.

CADPAAC is in the process of developing a model plan that would provide a continuum of services for those seeking treatment for alcohol and other drug abuse. Because of the multifarious nature of alcohol and other drug abuse diseases, a benefit plan must include such a continuum of services so that an individual can receive care that best suits their needs. CADPAAC respectfully submits to you a DRAFT of "California State Demonstration for Improved Alcohol and Other Drug Abuse Service Benefits". The proposal reflects and incorporates the delivery system for alcohol and other drug abuse services that has been developed in California over the last twenty years. This system has proved to be successful and cost effective. Those in the field have learned that: 1) an effective delivery system is based on recognition of the diversity of treatment modalities and 2) non-medical therapies that support alcohol-free and drug-free lifestyles are most successful.

2. SEPARATE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT.

Mental health benefits are important services for the Health Security Act's basic benefit plan. However, there is concern that the Alcohol and Other Drug Abuse Services benefit has been merged with the Mental Health Benefit. Persons who are chronically mental ill and are also alcohol and other drug abusers present a unique challenge to service providers. Coordination of services for the dual diagnosed is essential so that referral and treatment are appropriate. We believe that the referral function and monitoring of treatment is best performed by the case manager/gatekeeper as described in the Health Security Plan rather than prescribed in the legislation. Many of the obstacles we face in more effectively serving this caseload tend to be related to regulatory issues and problems in coordinating services in what generally tends to be separate service systems.

We recommend the two benefit packages be separated for the following reasons:

Approach/Philosophy to Treatment. The nature of mental illness is fundamentally different from the nature of alcoholism and other drug abuse. And, the modalities and course of treatment differ correspondingly. Mental illness tends to be a chronic, often gravely disabling condition. Mental health treatment is based on the use of a medical model, where psychotropic medication is a necessity to stabilize and to manage the chronic and permanent pathology of mental illness. While there may be periods of remission, in which these symptoms may lessen in severity and some may be "cured", for many persons the general course of mental illness is such that lifelong medical management is necessary. On the other hand, while there are certainly chronic alcoholic and drug addicts, many are "cured" in that they are able to lead clean and sober lives. Recovery happens as the result of a personal decision not to drink or to take drugs. Unfortunately, persons with mental illness are not able to make such a choice about their disease.

In California, the Mental Health systems focuses on the chronically mentally ill population. Crisis intervention, hospitalization, case management and monitoring of medication regimes are primary services. On the other hand, the alcohol and other drug abuse treatment system emphasizes the achievement and maintenance of abstinence that can enable those in recovery to be full participants as taxpayers rather than receivers of tax-supported services. Millions of individuals across the country have become and remained "clean and sober" without medical intervention.

Costs of treatment. It is estimated that treatment for mental illness is 10 times the cost of treatment for alcohol and other drug abuse in California. Not only is the cost more, the number of individuals treated in the system may be less. We will be providing you with additional cost estimates as the figures become available.

3. MAINTAIN AND STRENGTHEN THE SAMHSA BLOCK GRANT.

The SAMHSA Block Grant funds the prevention and treatment infrastructure in this country for those who are disenfranchised from medical services. The Block Grant provides funding to programs which primarily serve persons far outside the mainstream of American life; minorities, homeless, criminal offenders. These individuals do not utilize/access the traditional medical services because the services are simply not

available and they are distrustful of government services. These individuals are not effectively served by the health care system now and it is doubtful that they will become any less alienated under Health Care Reform.

Alcohol and other drug abuse problems are far more extensive than simply the personal struggle against alcohol and other drug dependencies. Families, schools, and communities are impacted by these problems. Extensive research and twenty-five years of experience have given the field effective tools to assist these institutions to prevent problems and to help repair the damage in our communities. Congress must proceed with great caution prior to any restructuring of this funding source.

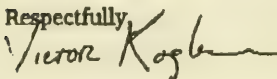
4. INCLUDE ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS AS AN "ESSENTIAL COMMUNITY PROVIDER".

Community based Alcohol Recovery and Drugs Treatment providers must be included as Essential Community Providers. The network of programs and services currently funded through the SAMHSA block grant are an important link to communities and to the education institutions. Their ability, skill and knowledge about recovery and treatment must be utilized to its fullest. Because of their longstanding credibility in communities they are often the only trusted health/health-related service that individuals will access. This situation is most acute in minority communities.

The County Alcohol and Drug Program Administrators Association of California (CADPAAC) is an association of the state's 58 county drug and alcohol programs that, through state subventions, are responsible for implementing the federal substance abuse block grant. The mission of the association is to reduce the abuse of alcohol and other drugs.

CADPAAC members will be in Washington D.C. in late February, 1994. We will soon be calling to schedule a meeting with you and your staff to further discuss integration our recommendations for Alcohol and Other Drug Abuse Treatment Benefits into the national health care health care Health care package and the importance of continuation of the SAMHSA Block Grant.

Respectfully,



Victor Kogler,
President

cc: Task Force Members:

The Hon. Paul Domenici
The Hon. Paul Inouye
The Hon. Edward Kennedy
The Hon. Paul Simon
The Hon. Alan Simpson

Mrs. Hillary Rodham Clinton, Chairperson, Health Care Reform Task Force
Mrs. Tipper Gore
Ira Magaziner, Staffperson, Health Care Reform Task Force
Donna Shalala, Secretary, U.S. Health and Human Services Agency

**COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS
ASSOCIATION OF CALIFORNIA**

**CALIFORNIA STATE DEMONSTRATION FOR
IMPROVED ALCOHOL AND OTHER DRUG ABUSE SERVICE
BENEFITS**

OUTLINE

I. Definitions - Services. Alcohol and drug services are those services provided with the primary purpose of early intervention, assessment, treatment, recovery, and rehabilitation from an alcohol or other drug abuse problem.

After each service, two to three pages of definition and additional information will follow. Issues to be addressed for each service include billing units (staff time or client days), minimum staff/client ratios, required staff credentials/experience and licensing, service sites, utilization review, required documentation (treatment plans and progress notes), and required services.

A. Early intervention services

1. Crisis intervention
2. Intervention (assessment, diagnosis, and referral)

B. Detoxification services

1. Residential and non-residential detoxification
2. Pharmacotherapeutic detoxification

C. Outpatient (nonresidential) services

1. Counseling services
2. Pharmacotherapeutic treatment
3. Intensive Outpatient (Day) Treatment
4. Social Model non-residential recovery
5. Case Management
6. Continuing care, aftercare and relapse prevention
7. Vocational rehabilitation

D. Residential services

1. Residential 24-hour short term care
2. Transitional residential services (therapeutic community)
3. Transitional residential services (recovery home care)
4. Sober living residence

E. Wraparound and Enabling services

1. Wraparound services - outreach, early intervention, transportation
2. Enabling services - vocational training, childcare, staff training

II. Target Population. The target population is youth and adults who have alcohol and drug abuse service needs.

A. Service population. Clients must be eligible for Medicaid, and must meet medical necessity requirements.

B. Medical Necessity. Medical necessity is a federal requirement which means that the individual has a need for the Universal Health Care services that are to be provided. Services to the target population must be medically necessary.

With certain exceptions, for example, assessment and crisis services, services will be reimbursable only when provided in accordance with a documented alcohol and drug abuse service plan.

Medical necessity is determined by meeting specified criteria. In mental health Medi-Cal, the criteria are DSM III-R diagnoses and one or more functional impairments. These include impairments in independent living, social relationships, employment, physical condition, ability to parent or care for dependents, or a history that demonstrates that without service there is a high risk of these functional impairments.

This section will detail who will determine medical necessity. In mental health Medi-Cal reimbursement, professionals other than physicians can determine medical necessity. These include psychologists, social workers, M.F.C.C.s, and Registered Nurses.

N.B. This issue requires considerable discussion within the substance abuse recovery field. At least, we should determine what services will be reimbursable and what services will not

III. Provider qualifications and program standards.

A. Provider standards. The county alcohol and drug services system will be the provider. The county will be certified by the DADP. This certification will be the approval of a Quality Management Plan.

B. Program standards. Services will be provided by alcohol/drug service programs which have been certified by the county as meeting

the standards for participation in this Benefit Plan. Programs may be county operated or county directed contracts. Separate certification will be required for each provider.

Individual counties will not develop unique additional certification requirements as part of this benefit plan. This would not preclude counties from developing additional standards, but these standards would be enforced by licensure or some other method, not through benefit plan certification. Procedures for cross-certification may be specified in the plan, in order to prevent an onerous requirement that providers operating in more than one county must be certified in every county.

Minimum standards for program certification:

1. Health and safety standards, service delivery criteria, county quality management plan, compliance with all existing governmental requirements (such as local licensure), and compliance with administrative, fiscal and client record requirements.

Standards for fiscal accountability, including opening records for audit, will be defined. Evidence of financial solvency will be one part of the requirement

2. All programs will be required to ensure availability of staff (*credential level to be specified*). In instances where clients exhibiting specified symptoms or high risk behaviors (*i.e., suicide threats, etc.*), a particular protocol will be followed (*to be specified*).

C. Service sites. Service sites include existing alcohol and drug programs, schools, client's places of residence, residential treatment facilities, public or private facilities suitable for group or individual services, on the street, or any other location, when necessary to reach and serve the target population efficiently and appropriately.

D. Service periods.

This section defines the admission period and the ongoing services period, and details the length of time for each period, what services are provided during each period, client eligibility criteria for the period, and the documentation required in order to provide service during the period.

The county will be responsible for developing a system that coordinates service delivery. There will be an admission period that will not exceed *[a number to be determined]* months to obtain assessments/evaluations, begin initial service delivery and develop a Coordinated Recovery Plan.

After the admission period, services will be based on a comprehensive client assessment, which results in a Coordinated Recovery Plan. The assessment/evaluation must document that the client is a member of the service population, i.e., has an alcohol or drug abuse problem. Each client will have a Coordinated Recovery Plan which will specify all planned alcohol and drug services to be provided with the county system. There must be a Service Plan to guide each of the authorized planned services.

E. Service planning. All plans require prior authorization by an alcohol and drug services professional *[qualifications to be specified]* and are subject to utilization review every 6 months. *(In mental health Medi-Cal, the professionals include: psychiatrist, psychologist, LCSW, MFCC, or RN.)* Each client service plan includes a client assessment, a multi-agency plan, and a treatment plan from each provider.

Service planning includes an assessment to determine needs, skills and desires of the individual; establishing long-term goals; accessing services to be provided; coordinating those resources. This includes identification of cultural and linguistic needs and barriers that may impede the ability of the system to deliver appropriate services. Clients will be involved in the development of service plans.

A "Coordinated Recovery Plan" is a system-wide plan for all the services a client is to receive from any the agencies in the system. A Coordinated Client Plan would typically be completed by a case manager.

Each provider then develops a "Service Plan" (like a treatment plan) for the particular service each client receives. For each provider specified in the Coordinated Recovery Plan, there will be a Service Plan. The Service Plan includes short-term goals, activities to achieve those goals, anticipated frequency and duration of services to be provided, and the person or team responsible for the activities.

IV. Quality Management. *The goal of quality management is the continuous improvement of services and efficient use of resources. Quality Management lays the foundation for a system of managed care. It requires ongoing evaluation of the process and structure of service delivery and outcomes achieved.*

A. Quality Management Plan. *The county will be required to develop and implement a quality management plan, which includes methods of maintaining and improving service quality, and utilization control and utilization review plans. Participating providers will have specified reporting requirements of evaluation and utilization data, probably very similar to existing reporting requirements.*

B. Quality Improvement *involves a continuous process of system review, including reviews of client case records and components of the service delivery system, such as specific programs. It also includes performance measures such as process and outcome evaluation data, including review of populations served and costs of service. Schedules and methods of giving feedback to programs, and Peer Review by other providers, may be specified as a part of the Quality Improvement effort. Each county will describe its system for quality improvement in its Quality Management Plan.*

B. Utilization Management *is the process for ensuring appropriate use of resources. The Coordinated Recovery Plan, Utilization Control, and Utilization Review are the components of the Utilization Management system. Utilization management is a process that is focused on efficient use of services and compliance with minimum service delivery standards. This process includes Utilization Control (prior authorization) and Utilization Review of services after the admission period.*

1. Utilization Control *is the requirement of prior approval of some services, in addition to inclusion in the Coordinated Recovery Plan. This function may be delegated to the program.*

2. Utilization Review *is a method used to ensure efficient use of resources. Random and targeted samples of case records are reviewed for compliance with requirements and effective use of resources.*

V. Rate Setting and Payment

A. Reimbursement rates

These do not necessarily have to be set in this document, but will need to be set.

Currently, mental health Medi-Cal bases reimbursement on the lowest of the following:

- 1. The provider's usual and customary charge to the general public for the same or similar services,*
- 2. Negotiated rates or net amounts, as approved by the state,*
- 3. The provider's allowable cost of providing the services, or*
- 4. The maximum allowable rates established by the state.*

B. Billing units and billing methodology will be developed and discussed as a separate subsection within each service definition.

C. Claims processing systems will be developed by the State of California Medi-Cal department in cooperation with the DADP and the counties.

VL DADP Oversight. The state will approve county Quality Management Plans, review county programs for compliance, and monitor financial solvency of subcontractors.

VII. DADP Assurances. Where implementation of this benefit plan will require changes in state or federal law, waivers will be submitted by the State Medi-Cal department to the Health Care Financing Administration.

**CALIFORNIA ASSOCIATION
OF
ALCOHOL AND DRUG PROGRAM EXECUTIVES, INC.**

The Hon. Paul Wellstone, Chairman
Working Group on Mental Health and Substance Abuse Benefits
Labor and Human Resources Committee
United State Senate - SD 428
Washington, DC 20510

Dear Sen. Wellstone:

RE: Health Security Act of 1974/Testimony for Public Record

Millions of dollars in annual health care costs can be saved through prevention and treatment of alcohol and other drug abuse. Those of us who work in the field know that thousands of individuals have, through our network of community based programs, changed their lifestyles and lead clean and sober lives. These programs rely on creating environments that are both alcohol and drug free. We know that people CAN change their lifestyles and their lives through programs that do not require medical intervention or drug therapies. Therefore, it is imperative that any national health care program include benefits for alcohol and other drug abuse treatment services.

The California Association of Alcohol and Drug Program Executives (CAADPE) has reviewed the latest revision of the proposed Health Security Act and respectfully submits the following recommendations and comments:

1. MAINTAIN THE ALCOHOL AND DRUG TREATMENT BENEFIT WITHIN THE HEALTH SECURITY ACT.

While this country has been waging a "War on Drugs", the vast human tragedy created by alcohol and other drug problems has

yet to be effectively addressed. Universal coverage for effective alcohol and other drug abuse treatment is absolutely essential. The treatment of alcohol and other drug abuse as a primary disorder has been determined to significantly offset other health care costs as well as costs associated with the criminal justice, social services and educational systems.

2. SEPARATE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT.

Concern has been raised that the Alcohol and Other Drug Abuse Services benefit has been merged with the Mental Health Benefit. Coordination of services for the dual diagnosed is essential so that referral and treatment are appropriate. We believe that the referral function and monitoring of treatment is best performed by the case manager/gatekeeper as prescribed in the Health Security Plan rather than dictated in the legislation. Many of the obstacles we face in more effectively serving this caseload tend to be related to regulatory issues and problems in coordinating services in what generally tends to be separate service systems.

We recommend the two benefit packages be separated.

The nature of mental illness is fundamentally different from the nature of alcoholism and other drug abuse. And, the modalities and course of treatment differ correspondingly. Mental illness tends to be a chronic, often gravely disabling condition. Mental health treatment is based on the use of a medical model, where psychotropic medication is a necessity to stabilize and to manage the chronic and permanent pathology of mental illness. While there may be periods of remission, in which these symptoms may lessen in severity and some may be "cured", for many persons, the general course of mental illness is such that lifelong medical management is necessary. On the other hand, while there are certainly chronic alcoholic and drug addicts, many are "cured" in that they are able to lead clean and sober lives. Recovery happens as the result of a personal decision not to drink or to take drugs. Unfortunately, persons with mental illness are not able to make such a choice about their disease.

In California, the Mental Health systems focuses on the chronically mentally ill population. Crisis intervention, hospitalization, case management and monitoring of medication regimes are primary services. On the other hand, the alcohol and other drug abuse treatment system emphasizes the achievement and maintenance of abstinence that can enable those in recovery to be full participants as tax-payers rather than receivers of tax-supported services. Millions of individuals across the country have become and remained "clean and sober" without medical intervention.

3. MAINTAIN AND STRENGTHEN THE SAMHSA BLOCK GRANT.

Alcohol and other drug abuse problems are far more extensive than simply the personal struggle against alcohol and other drug dependences. Families, schools, and communities are impacted by these problems. Extensive research and twenty-five years of experience have given the field effective tools to assist these institutions to prevent problems and to help repair the damage in our communities. Congress must proceed with great caution prior to restructuring this funding source.

The SAMHSA Block Grant funds the prevention and treatment infrastructure in this country for those who are disenfranchised from medical services. The Block Grant provides funding to programs which primarily serve persons far outside the mainstream of American life; minorities, homeless, criminal offenders. These individuals do not utilize/access the traditional medical services because the services are simply not available and they are distrustful of government services. These individuals are not effectively served by the health care system now and it is doubtful that they will become any less alienated under Health Care Reform.

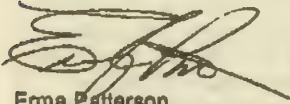
4. INCLUDE ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS AS AN "ESSENTIAL COMMUNITY PROVIDER".

Community based Alcohol Recovery and Drugs Treatment providers must be included as Essential Community Providers. The network of programs and services currently funded through the SAMHSA block grant are an important link to communities and to educational institutions. Their ability, skill and knowledge about recovery and treatment must be utilized to its fullest. Their longstanding credibility in communities that are disenfranchised is the only link to health care access.

CAADPE is a statewide organization composed of community based alcohol and other drug abuse treatment and recovery program executives representing the wide range of diverse service modalities in California. The primary objective of CAADPE is to reduce the alcohol and other drug abuse in California's communities.

CAADPE members will be in Washington D.C. in late February, 1994. We will soon be calling to schedule a meeting with you and your staff to further discuss integration of our recommendations for Alcohol and Other Drug Abuse Treatment Benefits into the national health care health care Health care package and the importance of continuation of the SAMHSA Block Grant.

Respectfully,



Emma Patterson,
President

cc: Task Force Members:

The Hon. Paul Domenici
The Hon. Paul Inouye
The Hon. Edward Kennedy
The Hon. Paul Simon
The Hon. Alan Simpson

First Lady Hillary Rodham Clinton, Chairperson,
Health Care Reform Task Force

Mrs. Tipper Gore,

Ira Magaziner, Staffperson, Health Care Reform Task Force

Donna Shalala, Secretary, U.S. Health and Human Services Agency



November 22, 1993

The Honorable Paul Wellstone
 Chairman, Working Group on Mental Health and Substance Abuse Benefits
 Labor and Human Resources Committee
 United States Senate - SD 428
 Washington, DC 20510

RE: Health Security Act of 1994 Testimony for Public R
 Dear Senator Wellstone:

Alcohol and other Drug abuse are costly to the nation in dollars, in pain and grief, in lives, and in reduced productivity. In fact alcohol and other drug abuse cost society a total of more than \$200 billion a year. According to one estimate, for every \$1 spent for drug treatment saves society \$11.54. Those of us who work in the Alcohol and Drug Program field know that thousands upon thousands of individuals are living sober and drug free lives today as a result of intervention from community based programs. We know that people can change their lifestyles through programs that do not require costly medical intervention or drug therapies. It is absolutely imperative that any national health care program include benefits for alcohol and other drug abuse treatment services including community based, non-medical programs.

The California Association of Alcoholic Recovery Homes (CAARH) has reviewed the latest revision of the proposed Health Security Act and respectfully submits the following recommendations and comments:

- **MAINTAIN THE ALCOHOL AND DRUG TREATMENT BENEFIT WITHIN THE HEALTH SECURITY ACT**
- **SEPARATE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT**

Alcohol and Drug Treatment and Recovery Programs operate on the premise that one must learn to live life without the use of mind altering drugs. Mental Health therapy relies on drugs to stabilize individuals suffering from mental illness. The two are not compatible. We learned in the 1960's that mental health therapies for the most part did not work with people suffering from alcohol problems. Alcoholism is an addiction and is not a symptom of deeper emotional problems. Some people suffer from dual addictions just as some people suffer from more than one physical or emotional disorder. This is not reason to combine the two programs.

- **MAINTAIN AND STRENGTHEN THE SAMHSA BLOCK GRANT**

The SAMHSA Block Grant funds the prevention and treatment infrastructure in this country for those who are disenfranchised from medical services. The Block Grant provides funding to programs which primarily serve persons far outside the mainstream of American life; minorities, homeless, criminal offenders. These individuals are not effectively served by the health care system now and it is doubtful that they will become any less alienated under Health Care Reform.

- **INCLUDE ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS AS AN "ESSENTIAL COMMUNITY PROVIDER"**

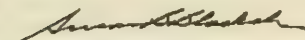
Community Alcohol and Drug Programs have effectively provided services to the majority of persons seeking services for alcohol and drug problems. They have proved to be outcome effective and cost effective. Their longstanding credibility in communities that are disenfranchised is the only link to health care access.

- **DO NOT CAP ESSENTIAL SERVICES BY DAYS OR VISITS, BUT BY NEED AND COST PER SERVICE**

Limiting long term residential services does not make sense. What does make sense is to limit high cost hospital or residential care by amount to be paid, not by days. To be effective, a residential program should be at least 90 days. The benefit is living in a sheltered environment while working on life skills. This can be provided for as little as \$2,700. in a residential social model program.

CAARH is a statewide organization which represents over 500 social model programs in California. We would be happy to meet with you and discuss these very important issues.

Sincerely,


Susan B. Blacksher
Executive Director

**STATEMENT OF THE
INTERNATIONAL ASSOCIATION OF
PSYCHOSOCIAL REHABILITATION SERVICES**

The International Association of Psychosocial Rehabilitation Services commends Senator Wellstone and his colleagues for their interest and concern that mental health services must be a strong component of health care reform legislation. IAPSRs represents over 1600 providers and practitioners of rehabilitation services for people with serious mental illnesses. This testimony supports our position that health care reform legislation must include a comprehensive mental health benefits package that includes services essential to the approximate 5 million Americans with a serious and persistent mental illness.

The Clinton Administration's Health Security Act has championed provisions for universal coverage, portability of benefits, an elimination of exclusions based on preexisting conditions, home and community based services, and access to a broad range of substance abuse and mental health benefits. They have taken steps to end a history of neglect and gross underfunding of essential community based health services for people with serious and persistent mental illnesses such as schizophrenia, major depression, and manic depressive disorder. For the first time intensive non-residential treatment services, which include psychiatric rehabilitation, will be available to all Americans who need such treatment for a serious mental illness.

However, the Administration's phase-in process for the substance abuse and mental health benefits package, subjects people medically in need of these services to arbitrary limitations until 2001. This weakens their initiative and is financially

unnecessary. It perpetuates a practice of discrimination towards people who seek mental health and substance abuse treatment. Furthermore, it serves our nation poorly when considering the estimated \$44 billion attributed to the indirect costs of lost productivity and earnings, as well as premature death, when severe mental illnesses are untreated.

Psychiatric rehabilitation services enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers and environmental barriers created by a serious mental illness. These services are provided nationwide and emphasize community based interventions to promote treatment in the least restrictive environment. Outcome studies show that psychiatric rehabilitation services are cost efficient and effective in reducing utilization for inpatient care. Research has documented a decrease in the number of days hospitalized and a decrease in the number of readmissions for people with a substantial history of institutional care. (See attachment on the Impact of Psychiatric Rehabilitation Programs on Rehospitalization.)

In light of the efficacy of psychiatric rehabilitation, it is particularly disconcerting that until 2001, the alternative treatments to hospitalization in the Administration's bill are juxtaposed in a combination of complicated trade-offs with inpatient care. Some individuals who might break the cycle of inpatient care with a course of intensive non-residential treatment, may preclude restorative treatment and skill development training. It is understandable that someone with a history of hospitalizations, would not want to not risk losing up to 30 days of additional inpatient care provided by their health plan, to prevent the potential for a hospitalization in the state psychiatric facility. These are choices that people should not have to make in a reformed health care system. Arbitrary limitations and trade-offs pronounce the inequities in a two-tiered mental health system, and how far we are from an integrated mental health system that merges the public and private systems of care.

The Administration imposes another burden on people with serious and persistent mental illnesses who require more than 60 days of non-residential intensive treatment services: 1 day deductibles, and 50% co-payments or \$25.00 for the following 60 days. Even for those individuals on SSI or 150% below poverty, the minimal cost would be \$5.00 a day of treatment. Although this may seem nominal to the Administration, people living on SSI as a result of a psychiatric disability typically have about \$10.00 a week of discretionary spending money after their rent is paid. \$5.00 a day to spend for a psychiatric rehabilitation program would be prohibitive. Health care reform legislation must do better for poor people who need mental health treatment.

Psychiatric rehabilitation services have been funded through state mental health authorities, and over 30 states have received funding from Medicaid to provide these services since the early 1980s. IAPSRs has been working with the Health Care Financing Administration to quantify the costs of community based psychiatric rehabilitation services. The following figures were received from staff in several state mental health authorities in response to a request by IAPSRs state chapter representatives:

Kentucky	FY 93	\$28.05 - \$65.08
Louisiana	FY 93	\$60.00 - \$100.00
Minnesota	FY 93	\$85.00
New Mexico	FY 93	\$78.00
New York	FY 93	\$30.00 - \$80.00
South Carolina	FY 94	\$90.00
Texas	FY 93	\$87.12
Virginia	FY 92	\$41.00

Clearly, psychiatric rehabilitation is cost effective for people with serious and persistent mental illnesses who choose this modality. Daily costs are often comparable to one hour of outpatient psychotherapy.

A suggestion by the Senate Working Group on Mental Health in a November 17, 1993 letter to Ira Magaziner, to remedy potential trade-off inequities reconfigures home-based, ambulatory detoxification and behavioral aides as a 4 for 1 trade-off while retaining psychiatric rehabilitation, partial hospitalization and day treatment as a 2 for 1 trade-off. This further complicates a flawed approach of trade-offs that promotes inappropriate or undertreatment for anyone receiving mental health services, and particularly for people with the most serious mental illnesses. It also illuminates the problems of combining restrictions on care for substance abuse and mental health services, when the limitations are already inadequate. These limitations will further erode efforts to respond appropriately to the dual diagnosis population, people with substance abuse disorders and a serious mental illness. People with serious mental illnesses and substance abuse disorders are particularly vulnerable to homelessness, and should not have such barriers to treatment and recovery.

IAPSRs asks those of you who have endorsed resolutions calling for a comprehensive mental health benefits package that provides mental health coverage equitable to coverage for physical illnesses, to remain firm in your support. IAPSRs further urges Members of the Senate Labor and Human Resources Committee to ensure health care reform legislation does not resort to arbitrary limitations for mental health services, complicated trade-offs among treatments, and burdensome co-payments and deductibles that would preclude the poorest and sickest in our Nation from receiving essential health care services.

IAPSRs would like to thank the Senate Committee on Labor and Human Resources for this opportunity to submit testimony. Please contact us should there be any questions or if we can assist you in any way.

Impact of Psychiatric Rehabilitation Programs on Rehospitalization

Author(s)	Outcomes Measured	Outcomes Measured	Outcomes Measured
Author(s)	Outcomes Measured	Outcomes Measured	Outcomes Measured
Arens, Hastings, & Herron (1991)	significantly fewer	63 to 19 days	n/a*
Bond, Withenidge, Dinan, Wasmer, Webb, & DeGraff-Kaser (1990)	from 3 admissions to 1 admission	54 to 26 days	n/a
Bond, Withenidge, Wasmer, Dinan, McCabe, Mewes, & Ward (1989)	n/a	n/a	participants rates dropped 50%
Bond, Miller, Krummard, & Ward (1988)	n/a	31 to 9 days	n/a
Ryan & Bell (1985, May)	n/a	n/a	nonparticipants = 61% participants = 26%
Bell & Ryan (1984)	n/a	n/a	nonparticipants = 48% participants = 33%
Bond (1984)	from 3 admissions to 1 admission	134 to 52 days	n/a
Cannedy (1982)	n/a	n/a	participants' rates dropped 74.92% overall
Dinan & Withenidge (1982)	n/a	87 to 36 days	nonparticipants = 44% participants = 14%
Withenidge, Dinan, & Appleby (1982)	n/a	87 to 37 days	n/a
Steen & Test (1980) Test & Steen (1980) Westbrod, Test, & Steen (1980)	significant reductions	significantly fewer days	significant reductions
Beard, Melamed, & Rossman (1978)	n/a	n/a	nonparticipants = 77% participants = 37%
Becker & Bayer (1975)	n/a	n/a	nonparticipants = 50% participants = 12%
Watson, Karmen, & Tanaka (1971)	n/a	n/a	clients attending 50+ sessions/yr = 0% clients attending <10 = 22%

*n/a = not measured in the study

Prepared by: Lisa Razzano, Ph. D., Thresholds National Research & Training Center, Chicago, Illinois.

INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES

Psychiatric Rehabilitation is an Essential Health Service for Persons with Serious and Persistent Mental Illness

Introduction

As our health care system is undergoing massive changes, it is important for us to consider those who are most vulnerable and most in need of a safety net of health care services. Persons with serious and persistent mental illness have historically been high utilizers of expensive health care services. Over the last 20 years, a concerted effort to find more effective and lower cost alternatives to long term institutionalization has led to the development of psychiatric rehabilitation services. This field of services has developed to respond directly to the high risks that many persons with serious and persistent mental illness experience of repeated hospitalizations, high utilization of emergency room services, low levels of functioning in the community, homelessness, and unemployment.

There is a growing body of evidence that psychiatric rehabilitation, also known as psychosocial rehabilitation, is an effective and cost efficient alternative to other forms of mental health treatment. Research in psychiatric rehabilitation services has demonstrated lower hospitalization rates, higher levels of functioning, higher levels of client satisfaction, and higher rates of employment than patients not receiving psychiatric rehabilitation services. The strong indications are that psychiatric rehabilitation services make a crucial and positive difference in the functioning and independence of persons with serious and persistent mental illness. Medicaid currently funds psychiatric rehabilitation services under either the rehabilitation or the clinic options in most states, providing essential safety net services for hundreds of thousands of persons with serious and persistent mental illnesses. Today there are more than 2000 agencies providing psychiatric rehabilitation services in the United States, as well as programs throughout much of the world.

The services and terminology of psychiatric rehabilitation are not always well understood. This is a short description of the needs of the population served, and the impact of psychiatric rehabilitation services on these needs, a summary of outcome and cost effectiveness research, and the importance of psychiatric rehabilitation in health care reform for persons with serious and persistent mental illnesses.

The Needs of Persons with Serious and Persistent Psychiatric Disabilities

Approximately 2.1% to 2.6% of the population of the United States experiences a serious mental illness which has affected the individual's ability to function effectively (Barker et al, 1992). More hospital beds are used for psychiatric illnesses than any other diagnosis, despite a significant reduction in state hospital beds over the last decade. Not all people with serious mental illness need psychiatric rehabilitation services. A frequently used method of defining the population in need of at any given time is to look at a combination of diagnosis, duration and level of disability.

The most frequent diagnoses of persons needing psychiatric rehabilitation services are schizophrenia, manic depressive disorders and depression, and severe personality disorders. Duration refers to the chronicity of the disorder and usually means a series of hospitalizations, a series of relapses of the illness, or symptoms which remain over a period of years. The last criterion, disability, is particularly important for assessing the need for psychiatric rehabilitation services and refers to the impaired functioning of an individual due to the illness. Each of the major mental illnesses has a significant impact on functioning. A description of the effects of schizophrenia on functioning will highlight how the symptoms and functioning interact.

In schizophrenia there are two groups of symptoms, acute symptoms and residual symptoms. The acute or positive symptoms are so called because they describe symptoms that are additions to normal behavior. These symptoms may include hallucinations (hearing or sensing something that does not exist), delusions (false beliefs), and bizarre behavior. Acute symptoms are most frequently treated with medications. The residual or negative symptoms describe those things which are losses to the individual with schizophrenia and include anhedonia (diminished ability to experience pleasure), apathy (lack of feeling), social withdrawal, poverty of thought (slow and confused thinking), blunting of emotion (emotional insensitivity), slowness of movement, lack of drive, and vulnerability to stress. Much of the pharmacological treatment of schizophrenia has had little effect on these residual symptoms. There may be a number of cognitive deficits as well, including impaired attention and memory, a handicapped ability to transfer learning from one situation to another, impairment of logic, and a damaged ability to think abstractly. These symptoms have serious impact on the ability of a person to function effectively in every day life.

In addition to the acute and residual symptoms, there are secondary symptoms related to the individual's and to the community's reaction to the illness, which may interfere with recovery and treatment. These secondary symptoms include a sense of hopelessness and helplessness, low self esteem, and a fear of taking risks (as in resuming normal life activities). The stigma of mental illness is so pervasive and harmful that most people diagnosed with a serious mental illness must also cope with rejection, misunderstanding and fear from those around them.

While medication and other treatment services may affect some of the symptoms of the illness, the functional deficits are best addressed by psychiatric rehabilitation. The functional limitations frequently seen in a person with a mental illness may include deficits in daily living, impaired social interactions, ineffective problem solving, a diminished ability to maintain relationships, and a marked impairment in role functioning.

Psychiatric rehabilitation is designed to help an individual capitalize on his personal strengths, develop coping strategies to deal with deficits and the symptoms of the illness, and develop a supportive environment in which to function as independently as possible. Most serious mental illnesses are cyclical in nature, and a combination of medication and psychiatric rehabilitation can help diminish the likelihood and impact of relapses and rehospitalizations.

A number of persons with serious and persistent mental illnesses also have other illnesses or disabilities. Other health problems such as epilepsy, diabetes, or high blood pressure are not uncommon because of the poor health care received by many persons with mental illness. The incidence of substance abuse is growing dramatically in this population. Mental retardation is a common second disability. The frequency of HIV positive is also growing. Psychiatric rehabilitation services must coordinate and provide care to meet the broad range of needs.

Psychiatric Rehabilitation Services

The goal of psychiatric rehabilitation is to enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers and environmental barriers created by the disability, and to restore ability for independent living, socialization and effective life management. Interventions help the individual learn to compensate for the effects of the symptoms of the illness through the development of new skills and coping techniques, and a supportive environment. They also counteract the effects of the secondary symptoms by restoring a sense of confidence and building on the strengths of each person, emphasizing wellness rather than illness.

An assessment process helps define the specific areas of functioning that have been affected by the symptoms of the mental illness and the strengths which can be used to counteract any functional deficits. The assessment process is usually situational --- observing the individual in activities of the every day life and identifying areas of daily living, social relationships, problem solving, etc. which are difficult for the individual to manage. Once the functional deficits and strengths are identified, a rehabilitation or treatment plan is developed with the individual who has a mental illness.

Through the activities of the psychiatric rehabilitation treatment program, the individual then works on restoring and/or learning the skills needed to compensate for the functional deficits, as well as accentuating the strengths he brings to the rehabilitation process. Those deficits frequently fall into several categories --- daily living skills, social interactions, and problem solving (cognitive processes). For instance, problems with daily living might include poor personal hygiene, difficulty with cooking and caring for the home, or inability to use public transportation. Problems with socialization might include isolation and withdrawal, inappropriate social behavior, and poor verbal skills. Cognitive deficits often lead to difficulty in thinking through and planning tasks, making decisions, following directions, clarifying the intent of others, and completing activities.

Activities of a psychiatric rehabilitation program are designed to be the real activities one engages in every day. There is a strong emphasis on activities which are normal, integrated into the regular life of the community and have real, tangible outcomes. There is often a poor transfer of learning from one situation to another for a person with a serious mental illness. Therefore, it is crucial that the rehabilitative process take place in the real community in which an individual lives. For this reason, psychiatric rehabilitation may be provided both in a psychiatric rehabilitation facility and "off site" in the community or in an individual's home. By tailoring the psychiatric rehabilitation to the individual's needs, rather than to a location, the effectiveness of rehabilitation is enhanced. This experiential learning process is one of the most effective ways to address functional deficits.

Some psychiatric rehabilitation programs design their activities to focus on the various aspects of running the program (clerical unit, food unit, maintenance unit, etc). Other psychiatric rehabilitation agencies design activities with a more educational emphasis such as groups or classes in problem solving. The activities are almost always group oriented to allow for peer support, feedback and assistance. The development of competence and successes are celebrated by the groups.

The psychiatric rehabilitation staff may coordinate the care given across a range of providers through case management, as well as providing treatment and rehabilitation services directly to the client. This case management is essential if the broad range of needs of persons with serious and persistent mental illness are to be met. Case managers do whatever is needed to make sure the gaps in services are filled effectively, and that services meet the actual needs of the individual.

Another psychiatric rehabilitation service offered in some areas is residential treatment and/or crisis residential services, which provide an effective and low cost alternative for those individuals who would otherwise be hospitalized or placed in other institutions (skilled nursing facilities, nursing homes, jails, etc). These programs provide intensive treatment and rehabilitation in a home-like setting, integrated into the normal community. Such programs offer a low cost alternative to inpatient settings, while providing the intensive services needed to assist an individual with a crisis or relapse, and help him in reintegrating into the community.

Other services may be offered such as substance abuse treatment, family support groups, medication management, crisis intervention services, etc. The bottom line for psychiatric rehabilitation services is to do whatever it takes to ensure the needs of the client are being met.

Psychiatric Rehabilitation Terminology

While the activities used to learn and practice new coping strategies may appear to be vocational or educational activities, it should be clear that work or education is not the goal of such activities any more than learning to swim is the goal in hydrotherapy of a physical injury. For example, a young woman with schizophrenia may participate in the food unit preparing lunch. The effect of the mental illness is evident in her slow movement and disinterest in the activities around her (apathy), in her withdrawal from interactions with others (isolation and withdrawal), and in the difficulty she has understanding and communicating with others (cognitive deficits). The intent of

rehabilitation is not to teach her to cook or to find a job in a restaurant. Rather she is learning to follow directions, to ask for clarification when she does not understand, to complete tasks, to relate to others appropriately, to control bizarre behavior, etc. Most importantly, she is learning to manage the symptoms of her illness in a normal setting. Such activities also raise self esteem, combat hopelessness, and provide a testing ground for new coping skills in a supportive and caring environment.

Early in the development of psychiatric rehabilitation, it was recognized that the role of the "patient" can be counterproductive to the rehabilitative process. For many people who have had long or frequent periods of institutionalization, the primary identifications of themselves as a mentally ill patient has contributed to passivity, acceptance of bizarre behavior, low tolerance for risks, and low self esteem. Efforts have been made to diminish the patient role and to strengthen the individual's commitment to the rehabilitative process. It is typical to find an informal, first name relationship between practitioners and clients. Rather than clients or patients, the recipients of services are frequently called members or associates to underscore the working partnership. The language used to describe services (skills training, clubhouse activities, support groups, classes) is purposefully non-medical.

The terminology used to describe the rehabilitative process has led to much confusion by health care policy makers which separate long term support services, vocational rehabilitation services and educational services from health care. While psychiatric rehabilitation agencies may also offer long term support, vocational rehabilitation and educational services, the psychiatric rehabilitation process is an essential component of the treatment of the mental illness and the restoration of functioning. It is important to understand that the deemphasis of medical and clinical terminology is an intentional effort to help the individual overcome the disabling effects of the mental illness in his or her life and to underscore the productive, coping abilities that are developing.

Community Support System

In recognition of the diverse needs of persons with serious and persistent mental illness when they leave psychiatric institutions, the National Institute of Mental Health developed the Community Support Program in 1977 to foster the growth of community support systems for the care of persons with serious and persistent mental illness. A community support system is defined as "an organized network of caring and responsible people committed to assisting persons with long term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community."

To address the range of needs, community support systems need to include treatment, rehabilitation, housing, vocational rehabilitation, case management, income supports, crisis response, case management, health and dental care, peer support, and family and community support. In concert with the goal to work with the whole person, psychiatric rehabilitation facilities frequently offer services that are not necessarily considered health services. The provision of these related services has a direct impact on reducing utilization of health care services. The most common services include housing, vocational rehabilitation and education. These services are funded through sources other than Medicaid, Medicare or insurance. Only by working with all aspects of the person can psychiatric rehabilitation be as effective as possible.

Housing - One of the most fundamental needs for every person is a place to call home. Room and board are not considered part of health care services. Many programs combine the room and board with psychiatric rehabilitation services to assist an individual to live in a much more independent living situation. Rehabilitation agencies frequently offer a range of housing services including group homes with intensive rehabilitation, supervised apartments, and supported housing. Supported housing programs assist each individual in finding a home of their own and then provide the rehabilitation services necessary to assist the person to function effectively at home. Supervised apartments are usually apartments shared by several people, with varying levels

of staff supervision and rehabilitation services. Group homes and halfway houses usually include a larger number of residents and the most intense level of psychiatric rehabilitation services.

Education - Because the onset of mental illness frequently occurs in adolescence, many people with serious mental illnesses have had interrupted educations. For those persons who live in areas where education is frequently limited, there is the secondary effect of limited education. Rehabilitation agencies frequently offer literacy and GED classes. Members may also be assisted in attending college or specialized training programs (supported education).

Vocational Rehabilitation - The characteristic that most defines us in our culture is our work. People with mental illness describe getting a job as one of their top priorities. Rehabilitation agencies usually offer vocational rehabilitation services which might include supported employment, transitional employment, group placements, agency run businesses, and sheltered workshops. In supported employment, a job coach continues the psychiatric rehabilitation process on the job by providing the training and support an individual needs to work effectively. In transitional employment, a person may work at a series of part time placements with the assistance of a staff member, and then move on to full time, permanent work. Many programs also have group placements which work in competitive jobs with staff supervision. Agency run businesses which hire workers with psychiatric disabilities provide a range of opportunities. Consumer run businesses are also a growing alternative.

An example of the interrelatedness of health care and these support services was demonstrated by a recent study by Bob Drake (1992). The study examined two similar partial hospitalization programs for treatment of mental illness. When one was converted into a vocational rehabilitation service, the researcher found the converted program led to a significant reduction in health care services utilization, and a significant increase in employment of clients, without any increase in mental health risk factors between the two groups. Health care utilization can be significantly reduced by ensuring access to these other crucial support services.

Outcomes Research

While outcome research in psychiatric rehabilitation is a relatively new initiative in mental health research, there is a growing body of evidence that psychiatric rehabilitation, including case management services, has a positive impact on the lives of people with serious and persistent mental illness, as well as a reduction in hospitalizations. In a review of 35 studies, Dion and Anthony (1987) found psychiatric rehabilitation interventions reduced hospital recidivism, and positively affected employment, skill development, client satisfaction, and the amount of time spent in the community. The reduction of hospital utilization as subjects participate in psychiatric rehabilitation and/or case management services is well documented and a consistent finding in many studies (Bond et al, 1984; Bond, 1988; Dincin and Witheridge, 1982; Fairweather and Fergus, 1988; Hammaker, 1983).

Assertive community treatment is one of the most widely researched approaches in psychiatric rehabilitation. In a Stein and Test study (1980), experimental subjects had significantly less time in psychiatric hospitals, higher occupational functioning and were less symptomatic after 12 months than control patients. In a similar study over 30 months, the control patients have been hospitalized nearly 5 times as often as the patients receiving assertive community treatment (Mulder, 1985). In a study by Hoult (1984), after 1 year the experimental patients were less symptomatic, higher functioning, and more satisfied with their care, as well as experiencing fewer and shorter hospital stays, than the control subjects. In a 5 year study (Borland et al, 1989) hospital admissions were reduced between 19 and 32 percent from the annual average for two years before assertive community treatment. Recipients of case management services demonstrate more stable community adjustments than those persons not receiving the services (Taube et al, 1990).

Similar results have been found with other models of psychiatric rehabilitation. Participation in a club house program is associated with higher life satisfaction by participants (Rosenfield and Neese-Todd, 1992). Skills training, a common psychiatric rehabilitation intervention, has been found to reduce clinical symptoms and relapse rates, as well as improve social skills (Wallace and Liberman, 1985). Participants in Fairweather Lodge programs show significantly reduced hospitalization rates and increased rates of employment (Fairweather and Fergus, 1988). Participation in psychiatric rehabilitation leads to an increased level of independent living (Bond et al, 1984).

The National Institute of Mental Health has made a commitment to increase research in rehabilitation. In the National Plan of Research to Improve Services (1991), NIMH has included a special section on rehabilitation research as well as outcome research in rehabilitation. The strong indications are that psychiatric rehabilitation services make a crucial and positive difference in the functioning and independence of persons with serious and persistent mental illness.

Cost Effectiveness

In addition to the clinical effectiveness of psychiatric rehabilitation, the cost effectiveness needs to be noted. In a review of cost effectiveness studies of Schizophrenia, Goldberg (1991) found community care was generally less expensive than care in a hospital. In an economic analysis of psychiatric rehabilitation, Bond (1984) reported savings in hospitalization costs, costs of community treatment and an increase in earnings in competitive employment related to participation in psychiatric rehabilitation services.

In another study examining intensive case management as an alternative service for those at risk of hospitalization, the intensive case management services were found to be a cost effective alternative to hospitalization (Weisbrod, 1983). In a review of the cost effectiveness of assertive community treatment programs, Taube and his colleagues (1990) demonstrated the cost effectiveness of assertive community treatment as an alternative to hospitalizations and standard after care treatment, particularly for those patients who were at high risk of repeated hospitalizations.

Most individuals served in psychiatric rehabilitation programs are former residents of state and private psychiatric hospitals, or would likely be long term patients in hospitals if psychiatric rehabilitation services were not available to them. For example, in a recent study of the Maryland Association of Psychiatric Support Services (MAPPS), an IAPSRs chapter, it was calculated that the cost of a state hospital bed in Maryland now exceeds \$100,000 per year, while a comprehensive array of community treatment and rehabilitation services -- including psychiatric rehabilitation, outpatient clinic visits, housing, and vocational rehabilitation -- is less than \$50,000 a year. The psychiatric rehabilitation component in that state costs \$54 a day, while state hospital care is \$275 a day and inpatient care in a private or general hospital is \$300 to \$500 a day. Even the most intensive forms of community treatment and rehabilitation provide less costly alternatives to hospitals.

Clinical effectiveness and cost effectiveness go hand in hand in this field. Good psychiatric rehabilitation not only reduces reliance on expensive hospitals, but also assists individuals with psychiatric disabilities to reduce their dependence on all public services and ultimately the taxpayer --- and achieve levels of productivity and independence considered impossible only a decade ago.

Conclusion

Serious and persistent mental illnesses can result in significant functional deficits that effect a person in every aspect of his life. Effective psychiatric rehabilitation services are aimed at minimizing these impairments in functioning and role performance, and restoring the individual to maximum functioning. By increasing functioning, the likelihood of relapse is diminished and

hospitalizations prevented. The interaction of psychiatric rehabilitation, vocational rehabilitation, educational services and housing helps underscore the rehabilitation process in every aspect of the individual's life. Psychiatric rehabilitation, in all its many aspects, coupled with medication is the treatment of choice for many individuals with a serious and persistent mental illness, and must be included in any health care reform initiative if these citizens are to break the cycle of institutionalization, decrease the use of expensive, less effective treatments and participate actively and productively in community life.

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FACTS ABOUT PSYCHIATRIC REHABILITATION

There is a growing body of evidence that psychiatric rehabilitation (also known as psychosocial rehabilitation) is both an effective and cost efficient treatment for persons with serious and persistent mental illness. These services have grown rapidly over the last 15 years and have become an integral part of our nation's mental health system. Health care reform legislation needs to include psychiatric rehabilitation services, if we are to address the health needs of one of the most vulnerable segments of our society, people with serious and persistent mental illness.

Serious and Persistent Mental Illness

Approximately 2.1% to 2.6% of the population of the United States experience a serious mental illness which has affected the individual's ability to function effectively. Today most people with a mental illness live in the community, rather than in an institution. Schizophrenia, affective disorders and depression often have a cyclical nature, with changes in functioning and symptoms occurring over time. The intensity and the type of health care services also vary over time, depending on the needs of the individual. The symptoms of a mental illness, such as schizophrenia may include:

- * **Hallucinations, delusions and bizarre behavior**
- * **Apathy, withdrawal, blunting of emotions, slowed motor activity**
- * **Cognitive deficits including impaired attention and memory, poor generalization of learning, impairment of logic, and a damaged ability to think abstractly**

While medications are effective in reducing some of the symptoms, the residual symptoms have a direct impact on a person's ability to function and live independently. Frequent hospitalizations, emergency room visits, and even incarceration or homelessness have been the outcome for those most severely affected by the mental illness. In an attempt to address this problem, psychiatric rehabilitation services developed and have become an integral part of our nation's mental health system.

What is Psychiatric Rehabilitation?

The goal of psychiatric rehabilitation is to restore the individual's ability for independent living, socialization and effective life management. Psychiatric rehabilitation services are designed to help an individual with a serious and persistent mental illness to:

- * **Develop coping strategies to manage the symptoms of the illness**
- * **Develop behaviors and skills to compensate for the functional deficits in activities of daily living , interpersonal relations, problem solving , and cognition**
- * **Develop a supportive environment in which to function as independently as possible**
- * **Build on personal strengths to offset the effects of the illness**
- * **Coordinate all treatment, rehabilitation and support services**
- * **Manage crises and relapses of the mental illness**
- * **Utilize community alternatives to psychiatric hospitalization when clinically appropriate**

There is a strong emphasis on activities which are integrated into the normal life of the individual and the community, and have real, tangible outcomes. Through this process an individual learns and practices coping strategies which help to offset the effects of the mental illness and allow a person to live more independently. The services may be provided within a facility or they may be provided off site, integrated into the normal community settings of the individual. Coordination with other mental health treatment services, both inpatient and outpatient, is provided. In addition to the treatment services, many psychiatric rehabilitation agencies also offer housing services, education, and vocational rehabilitation services to address the effects of the illness in all aspects of the individual's life.

Outcome Research and Cost Effectiveness

Outcome research in psychiatric rehabilitation consistently demonstrates the effectiveness of this approach. A number of studies examining the impact of participation in psychiatric rehabilitation services have reported consistent findings:

- * **Significant reductions in psychiatric hospitalizations**
- * **Increased level of functioning and level of independent living**
- * **Increased client satisfaction**
- * **Increased rate of employment**

In a review of 35 studies, Dion and Anthony (1987) found psychiatric rehabilitation interventions reduced rehospitalization, and positively affected employment, skill development, client satisfaction and the amount of time spent in the community. The reduction of hospital utilization, as subjects participate in psychiatric rehabilitation and case management services, is a particularly well documented and consistent finding in many studies (Arana, Hastings and Herron, 1991; Bond

et al, 1990; Bond et al, 1989; Bond et al, 1988; Ryan and Bell, 1985; Bell and Ryan, 1984; Bond, 1984; Cannady, 1982; Dincin and Witheridge, 1982; Witheridge et al, 1982; Stein and Test, 1980; Beard, Malamud and Rossman, , 1978; Becker and Bayer, 1975; Wolkon, Karmen and Tanaka, 1971.)

Psychiatric rehabilitation serves those persons most at risk of long term institutionalization. The cost effectiveness of these services is demonstrated not only in significantly lower hospitalization rates, but in reduced utilization of community treatment over time, and increased employment. Savings in other federal programs, such as Supplemental Security Income, also result when an individual is able to go to work.

Psychiatric rehabilitation is a necessary component of health care for persons with serious and persistent mental illness. It is an effective and cost efficient treatment intervention. Without psychiatric rehabilitation services, persons with serious and persistent mental illness are at higher risk for institutionalization, incarceration, and homelessness.

Senator WELLSTONE. This concludes the hearing of the Committee on Labor and Human Resources
[Whereupon, at 2:45 p.m., the committee was adjourned.]

THE HEALTH SECURITY ACT OF 1993: THE ROLE OF MANAGED CARE AND THE INSUR- ANCE INDUSTRY

TUESDAY, NOVEMBER 9, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room SD-430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Metzenbaum, Dodd, Harkin, Wellstone, Kassebaum, Jeffords, Coats, Gregg, Thurmond, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

At the outset, I want to express appreciation to all the witnesses who are here this morning and to apologize in advance for the absence of some of our members. We are in the process of the debate on the crime legislation, in which there is obviously enormous interest, which is taking place on the floor of the Senate. I believe we are secure in not being interrupted by votes, but there will be a good deal of coming and going, and we have a very full agenda which we hope to complete this morning because we are anticipating a series of votes throughout the afternoon immediately after the caucuses. So we will do the best we can.

In that spirit, I will put my full statement in the record as if read, and I want to thank all those who will be appearing today representing the different aspects of health insurance and who are joining us today in one of the key aspects of the health insurance debate.

Managed care is an important force in the health insurance industry and a key feature of the Health Security Act. And the hope is that managed care plans will help to hold down costs and improve quality in the new health care system.

PREPARED STATEMENT OF SENATOR KENNEDY

Today, the Senate Committee on Labor and Human Resources continues its series of hearings on the President's Health Security Act. This morning's session will focus on the role of the health insurance industry.

When we ask Americans what's wrong with the health care system today, the first thing we hear is how difficult it is to get insur-

ance and keep it. If you lose your job or change your job, you can lose your health insurance. Families who faithfully pay their insurance premiums year after year suddenly find their coverage canceled when a member of the family gets sick. Still others are labelled a "pre-existing" condition—and are denied coverage, or else their coverage is written in a way that excludes the care they need most.

Businesses must endure annual premium increases of 10 or 15% to cover their employees, and hikes of 20% or 25% are not uncommon. For small business, one employee with diabetes or asthma can make the entire firm uninsurable. Often, these businesses must shop for insurance in a market where they can pay up to twice as much in premiums as they ever expect to get back in benefits.

Choice of health plan and choice of doctor suffer too. Last year, more than 60% of firms with fewer than 500 employees offered their workers only one insurance plan. The non-choice that most employees have today is "take it or leave it." Increasingly, employers are dropping their fee-for-service plan, limiting choice still further.

We spend one-and-a-half times more per person on health care than any other industrialized nation—and we still leave one out of every six Americans without insurance. Few if any who have insurance today can count on it being there tomorrow.

For many years, health care has been the fastest growing failing business in America, and the insurance industry bears a major share of the responsibility for the crisis we face.

Some insurance companies have taken a progressive role in working with the administration to enact reform and enhance competition based on quality, efficiency and effective service. Unfortunately, the industry trade association—the Health Insurance Association of America—has continued to "just say no" to meaningful reform. They have launched a massive disinformation campaign about the President's plan in order to protect their profits and preserve the status quo. They have invested enormous amounts into this campaign—\$4 million at last count—enough money to insure the entire town of Essex, Massachusetts for an entire year. But this campaign will not succeed. People want reform, they want it now, and no negative advertising campaign can scare them as much as the future they face without meaningful health care reform.

Not too long ago, insurance companies used to offer coverage to everyone in the community and charge everyone approximately the same price, depending on the coverage they picked. No one was excluded from coverage. Companies followed the fundamental principle of insurance—the risk of illness or injury should be spread among as large a group as possible, in order to provide affordable coverage for everyone.

But in recent years, some insurance companies found that they could gain an advantage over their competitors by narrowing these pools and insuring only those who had the lowest risk. Some firms struggled against this destructive urge. Others gave in to it. They learned how to pry into individuals' medical histories to assess

their risks and decide whether to accept or reject applications for coverage.

This is the stark reality behind risk rating and other practices that have become standard operating procedure in the insurance industry today. It's a divide and profit strategy. It pits old against young, big business against small business, the healthy against the sick—and, increasingly, doctors against their patients.

It is time to end these insidious industry practices which are undermining the health care system and driving up costs.

The Health Security Act ends these abuses. It gives the insurance industry a chance to function once again in the best interests of the people of this country. Under the President's proposal, health plans will be required to compete on the basis of price, service, and quality instead of on their ability to accept good risks and reject bad ones. Many insurance companies and HMOs would prefer to compete in that way—on a level playing field where they can focus their energy and resources on providing better health care for all instead of denying coverage to the sick.

To achieve this reform, the President's plan establishes new ground rules for the insurance industry. Pre-existing condition exclusions and discriminatory pricing will be prohibited. Health plans will be required to accept all applicants, regardless of age or health status.

The Health Security Act restores the concept of large, community-rated pools. It includes a procedure for adjusting risks among plans, so that those serving relatively sicker people do not bear an excessive financial burden.

Individuals will have the opportunity to choose among plans, including at least one plan that guarantees a choice of providers at no extra charge.

The Health Security Act guarantees more choice than most Americans have today. This aspect is a fundamental feature of reform, because it reverses the present situation in which people are steadily losing their choice. Each plan will also provide information on quality and price, so that the choices made by beneficiaries will be meaningful.

Another feature of the proposal is that it places a limit on how much insurance companies can increase their premiums each year. These so-called premium caps are an important guarantee to the American people—a guarantee that the overcharging that is wreaking financial havoc on families and businesses across this country will come to an end.

Most of all, the Act gives families the security and peace of mind of knowing their health insurance will always be there when they need it.

Our hearing today deals with how insurance companies, HMOs, and other plans fit into this new system. Our first panel will address the role of managed care. Our second and third panels will consider these issues from the perspective of the health insurance industry and health insurance consumers. I welcome each of our witnesses, and I look forward to their testimony.

The CHAIRMAN. With us to testify today on the role of managed care are Malcolm Odell and his son Jamie from Amesbury, MA. I had the good opportunity to work with Mr. Odell on some matters

up in Amesbury, the oldest boatyard in the country, and he is very much involved in its historic preservation. The Odells come to share their experiences using their HMO, the Harvard Community Health Plan, to deal with a serious illness that Jamie has overcome. I would like to welcome the Odells today and thank Jamie very much for being here.

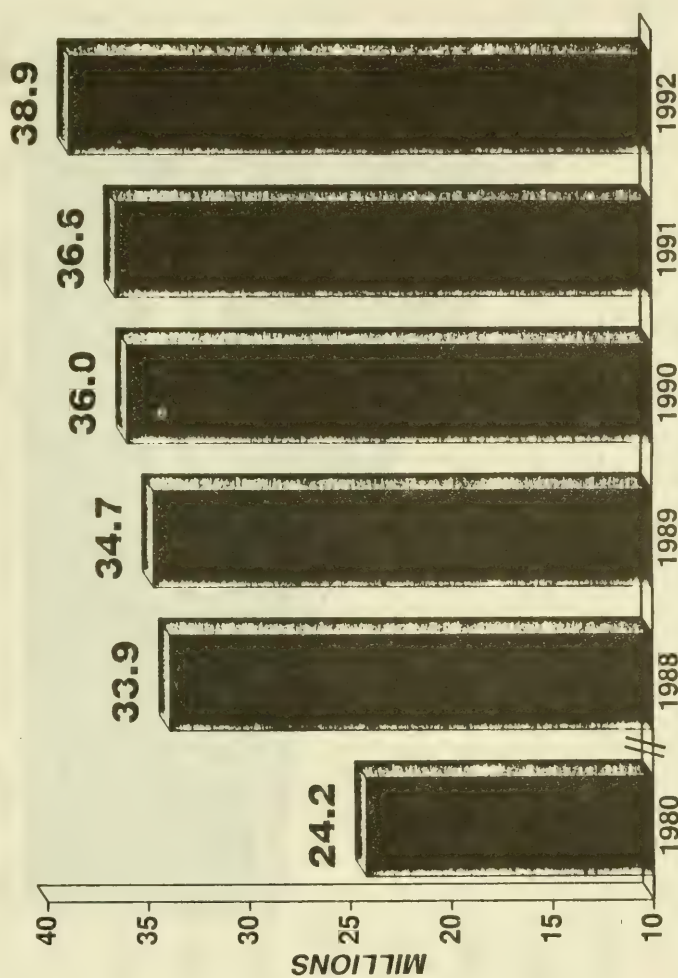
We also welcome James McLane, the CEO of Aetna Health Plans, who is here representing the Alliance for Managed Competition.

Kathleen Franklin is a registered nurse in charge of the prevention program at CIGNA Health Plans.

And finally, we will hear from Sara Nichols of Public Citizen, a well-known advocacy group here in Washington, DC.

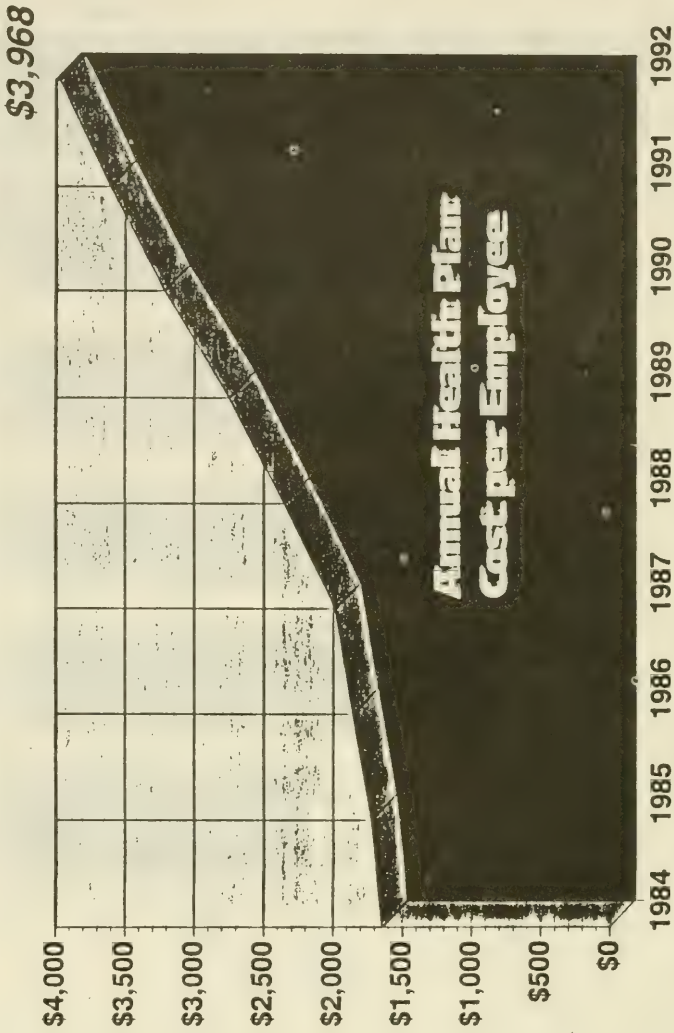
[Charts follow:]

The Number of Uninsured Americans is Large and Growing



Source: CPS (1992); EBRI tabulation of CPS (1988-91); Fu Associates Estimate (1980)

Premium Costs Are Soaring



Source: Foster-Higgins Health Care Benefits Survey 1992

Choice Is Rapidly Declining Today

- 42% of the American workforce has no access to a freedom-of-choice plan
- 30% of employers no longer offer a freedom-of-choice plan
- Only half of the workforce has a choice of health plans today

The Clinton Plan Will Guarantee Choice

- Individuals pick from a menu of plans offered through regional health alliances
- Every American will have access to a freedom-of-choice plan
- All plans including HMOs must offer out-of-network coverage

Sources: Foster-Higgins, Hewitt Associates, EBRI

Senator KENNEDY. We welcome all of you, and we will start with you, Mr. Odell.

Jamie, are you missing school today?

Mr. JAMIE ODELL. Yes.

The CHAIRMAN. I do not know how many times you have testified in the past, but you look like you can handle the situation very well, and we are grateful to you.

STATEMENT OF MALCOLM J. ODELL, JR., MEMBER, HARVARD COMMUNITY HEALTH PLAN, AMESBURY, MA, ACCOMPANIED BY SON JAMIE; JAMES W. McLANE, CEO, AETNA HEALTH PLANS, REPRESENTING THE ALLIANCE FOR MANAGED COMPETITION, HARTFORD, CT; KATHLEEN L. FRANKLIN, DIRECTOR OF PREVENTIVE HEALTH SERVICES, CIGNA HEALTH PLANS, SOUTH WINDSOR, CT; AND SARA S. NICHOLS, STAFF ATTORNEY, PUBLIC CITIZEN CONGRESS WATCH, WASHINGTON, DC

Mr. ODELL. Senator, if I get going too long, cut me off and put Jamie on; he is much more to the point than I usually am.

You have introduced us; I am Malcolm Odell, and this is my son Jamie. We live in a little blue-collar town on the Merrimack River up in Massachusetts near the New Hampshire border. We are members of an HMO. Before that, we were part of a regular 80/20-type insurance plan, the type we used to have commonly as a main system in the old days.

Part of our health plan also includes what they call a PPO, a preferred provider, which is affiliated to but not owned by the Harvard Community Health Plan, and we have been part of a Harvard-owned center as well. So that experience, for what it is, we will share with you.

In 1989 when Jamie was 11, I had a good job helping solve environmental problems here and overseas. My wife Marcia, 44—I was 50—had just started her own small business. It was a lovely June morning. School was out. My daughter was going to a doll carriage contest, and Jamie found that he was just having a hard time getting going. He felt very clumsy. He had trouble getting out of bed. When he came down to breakfast, he fell down the front stairs. When he got on his bike, he could not control it, and he almost ran into a truck driving by.

By noontime, we knew we had a problem. I had gone to work and was totally unaware of this. My wife Marcia, when she saw him just sort of drop as he was walking across the playground, said, "Something is not right here." She called our Harvard PPO, our pediatrician, and he promptly made space available. She went right over, and Jamie said the 25-minute wait was probably the longest wait in his life. He was really getting worried, and was beginning to fall apart.

Very quickly, a preliminary diagnosis was made that something was really wrong. Jamie was immediately referred to a neurologist specialist nearby. He went there straightaway and got right in to see him. The neurologist first thought it was a virus and said, "No, this is something else. I think it is Guillain-Barre Syndrome," and immediately put him in an ambulance for, as far as we are concerned, one of the best hospitals in the world, Mass General Hos-

pital, where he was, after an exciting ride, immediately under the care of one of the top specialists in the world, we later learned, the guy who writes the articles and presents the conference papers. Under his supervision, Jamie had a spinal tap.

By the time I found out about this, Jamie was already getting a spinal tap, and by the time I got through Boston traffic, they really had this thing under control.

They then proposed a very expensive treatment called plasmaphereses—we later learned it is unbelievably expensive, more expensive than dialysis. We did not know that, but they were immediately trying to put him on that system. Mass General could not handle it, and Jamie was immediately referred to Children's Hospital. Harvard opened the way and got him transferred over there, and got the thing going within 48 hours of the first time he fell down. He had two sets of those treatments.

We found basically that in that particular situation, Harvard Community Health cleared the way and helped make things happen. They did so without delay, without hassle, without paperwork, and without prodding. Doctors were making the decisions, and administrators were there to make things happen.

Some time later, just as an example, Jamie was in a long-term care facility, Spaulding Rehab, and he needed a special kind of wheelchair, a juvenile wheelchair. The hospital wheels went on and on for a couple of weeks. I got very frustrated, and I called our Harvard representative; the wheelchair was delivered the next day after the hospital, which is supposed to be one of the best in the country, had been fooling around for 2 weeks.

This seemed to be the way things went on for quite a while, but then we ran into some problems. As the thing dragged on, and he did not get better the way he was supposed to, the PPO overseeing his care seemed to be getting in the way more than it was helping. We were having constant problems getting referrals and one thing and another to the people he had originally been treated by under the first acute care set of opportunities. We were really frustrated, and at that point, we went to the Harvard system and asked what we could do.

They said, well, you do not have to be where you are. If this is not working for you, we have other clinics, other doctors, and other options. And literally with their active assistance, doctors helped us find another doctor who really wanted Jamie as a patient, a clinic that would like to have him, and had a referral network established that worked for his particular situation.

Once we got into that system, it was like a miracle had occurred. We really found a tremendous difference from this PPO-type setting. Again, we would have a referral, and if something got lost in the paperwork, they would fax the referral to the doctor in minutes. This was the way the system operated for us out of that clinic continually; red tape, paperwork—we never saw it. We had less paperwork, I think, for Jamie's mega illness than for the routine stuff we had had under our old insurer, reimbursement type stuff.

To this day, I have no idea how much this illness cost the Harvard system, and frankly, Harvard cannot tell me. They do not work that way. They are not looking to see who is costing them money. They said they could find out, but it would probably take

6 months of research. I guess this illness probably cost \$1 million, and in today's world, I could be wrong; it could be more than that, but I think it was certainly not less.

So we put together a new program, a combination, with their assistance, of a homemade Outward Bound program, sort of a confidence-building program to get out in the wilderness, to challenge ourselves and Jamie to really work on this thing, and a whole new set of doctors and a new treatment which was found by one of the top specialists in the world, in Holland, that had never been used in the United States. They immediately started it with Jamie, and it made a big difference.

There was never any question about, "Oh, this is research, and it has not been adopted yet," and so on. They did it, and it worked. In fact, it worked so well, with the Outward Bound program that we put together ourselves, climbing mountains, hiking, canoeing, whitewater rafting, and bungee-jumping—Jamie is the only one in the family who has bungee-jumped off a suspension bridge over a 150-foot canyon—all this went on, and he was making a fabulous recovery. He enrolled in a regular Outward Bound program and took a regular course for 15-year-old kids. He was under-age, underweight, and sub-physical condition. This was supposed to be for good, fit 15-year-olds, and he was not up to the age limit, but they took him anyway, because he really wanted to do it, and they thought it would help and they thought that maybe he could do it.

Well, my gosh. Not only did he get through the Outward Bound program, but at the end of it, they asked him if he could come back and maybe be a teacher in the future. He really made a difference for those kids.

Unlike other American families, however, in that particular setting—well, let me backtrack for just a minute. Jamie had made this tremendous breakthrough, they decided that he was really on the way to full recovery, so they stopped the treatments, and we went on to a normal life. We ordered some mountain bikes to treat ourselves for overcoming this ordeal. Before they were even delivered, however, I was off on a business trip, and I got word that he had been paralyzed again, totally, completely paralyzed again, after all this accomplishment.

The system went right into high gear for him immediately. They immediately put him back on the treatment and discovered, unfortunately as a guinea pig, that it had been making the difference. Harvard went on to continue the program that is continuing today, where every month he gets this special i.v. gammaglobulin.

But unlike most Americans, we have managed to keep our HMO coverage without interruption, because at the same time all this was happening, I lost my job. The economy in New England started to go down the tubes. My wife's new business could not get her attention because she had other, much more important things to do. So she had to dissolve her business. And the jobs that I had been working in went south. In fact, the only ones left in my field are right here, and I could not come here unless I wanted to split my family up. So I was locked into an excellent system, but to move out of that system with a pre-existing condition, it could not have happened, and second, under the system we were operating in, we would not want to pull Jamie out of that. So we were really caught.

Somehow, in the last 4 years, largely out of work, we have managed to keep up our premiums. I do not know—it is a miracle—how we have done it. Some of these years, the combined premiums and incidental expenses have been more than half of our total income.

I think Americans deserve a system of this type to take care of them. Compared to anything else we have ever seen, it is efficient, it provides access to state-of-the-art treatment, to first-rate outside specialists, it slashed our paperwork, was flexible, we could choose our own doctors and clinics within a very comprehensive network. It provided us with alternatives, and when we ran into real problems, it provided us with an appeal process and a way around it. It encouraged us to be our own advocates so that we could find something that worked better.

The CHAIRMAN. I will give you about another minute to wrap up.

Mr. ODELL. Thank you.

Without that plan, we would be in real trouble. Given the circumstances I have just described, Jamie would probably still be paralyzed. If we had not been able to solve the problem we ran into, he would be in much more serious condition than he is now. We would have been bankrupt, and I just do not know what we would have done. I shudder to think if we had been in any other type of system, frankly.

However, the only hole in all of this is that it falls entirely on us to carry the burden. We pay \$6,000 a year ourselves. I was able to keep the plan after my job went down the tubes, and we pay that ourselves. And if a situation like this happened when I am out of work, and I want to pay it, I am stuck. I would have to go on the dole, drop out of the whole thing, go on Medicaid or Medicare—it would have been just catastrophic.

So coverage for families without work is absolutely essential as a piece of this whole pie.

There needs to be a provision for long-term care. That is one of the holes in this and most other plans, I think, like this. The rehabilitation that goes on for months is tremendously important. And finally, the portability. You have got to have some way of making it portable. If you gentlemen and President and Mrs. Clinton can turn the economy around and put us back to work, and if you can find a way to carry our own health costs—and I speak broadly about “us,” those people in this situation—in the face of adversity, Jamie and the rest of us can get through these hard times without devastation. If that cannot be done, we are all in deep trouble, and it would place an even greater cost on an overstretched national budget, risking social disorder, or even greater national debt, and in our case, it would have completely ruined us.

The CHAIRMAN. Thank you very much. Jamie, I will have a question for you in a little while, but I will recognize Senator Dodd to introduce our next witness.

[The prepared statement of Mr. Odell follows:]

PREPARED STATEMENT OF MALCOLM J. ODELL, JR.

I am Malcolm Odell, this is my 16 year old son, Jamie. We come from Amesbury, MA a small, blue collar town on the Merrimack River near the New Hampshire border. Members of an HMO, we have been through a major medical crisis that hit us about the same time that I turned 50 and lost my job.

In early 1989 Jamie was 11, I had a good job helping solve environmental problems here and overseas, and my wife, Marcia, at 44, had just started her own small business. It was a warm June morning when Jamie began to feel unusually clumsy, attributing it to belated 'Spring Fever.' He fell down the front stairs on his way to breakfast, then he almost crashed his bike into a passing truck. By noon, Marcia realized that he was having trouble walking and that something was really wrong. By dinner he was completely paralyzed with a rare illness, Guillain-Barre Syndrome (GBS).

By that time, however, Jamie had been seen by his pediatrician, been referred immediately to a neurological specialist, then swiftly dispatched by ambulance from our local hospital to one of the world's top hospitals. Massachusetts General Hospital, where he was met by an HCHP liaison staffer and promptly put under the care of one of the world authorities on this rare illness. Jamie was already in the middle of a spinal tap by the time word reached me at work and I had made my way through the famous Boston traffic to MGH. The specialist recommended expensive, state-of-the-art plasmapheresis treatments, but when it became apparent that MGH was not equipped to conduct the treatment on a child, HCHP promptly transferred Jamie to Children's Hospital, where they were begun immediately. HCHP not only cleared the way to help make things happen, but it did so without delay, hassle, paperwork, or excessive prodding. When, some time later, a special juvenile wheelchair failed to appear through the hospital channels two weeks after being ordered, called HCHP. The wheelchair was delivered through HCHP's own channels the next morning. When a missing referral to an outside specialist jeopardized an important procedure, HCHP faxed a new one within minutes. When we encountered serious and mounting problems within the PPO overseeing the first year of Jamie's care, HCHP helped us to search their system for a clinic, referral network, and supervising doctor that better suited Jamie's special needs. We now drive past four other HCHP clinics on the way to the one that works best for us. Yet we often use those clinics for routine matters and any doctor or nurse in any center can pull up Jamie's complete and up-to-date computerized records in seconds.

In fact, the pure paperwork and red tape, despite months and months in 3 different hospitals, countless test, procedures, consultations, and orthotic fittings, has probably added up to less paperwork than we had from more routine health care under the normal 'fee-for-service' insurance plan we had prior to enrolling in HCHP.

After a grueling 2-year struggle that included finding a entirely new team of doctors and a developing our own Peace Corps-style, 'home-made' Outward Bound program to challenge Jamie outside the hospital setting, Jamie was close to full recovery. In celebration of that great accomplishment, and Jamie's 14th birthday in 1991, I ordered him a new mountain bike.

Before the bike was even delivered, however, Jamie suffered an unexplained '1-in 10 million' relapse and was completely paralyzed for a second time. Fueled by his 'Outward Bound' spirit, and a successful experimental treatment also underwritten by HCHP, which will continue for some time to come, Jamie was out biking and throwing a paper route within months.

He has made a marvelous, although still incomplete recovery, and he is looking forward to skiing this winter. This past weekend he volunteered to pedal as pacer-ider for the handicapped participants in the Massachusetts Special Olympics. He has been on the high school honor roll throughout this ordeal and we are looking forward to his returning to the ranks of ordinary kids in the near future.

The progress against enormous odds has not been without costs, however. At about the same time that Jamie went into the hospital, the organization I was working for began to slide toward bankruptcy, the economy in New England started crumble, and the few remaining jobs in my field were far away. Marcia's struggling new business had to be dissolved. In a matter of months, while we took turns sleeping in Jamie's hospital room to help him deal with paralysis and pain, our livelihoods vanished. Then shortly before his second paralysis, the Gulf War resulted in the unexpected cancellation of several short-term assignments I had lined up. I has been a gut-wrenching experience that has put our family under enormous stress economically, physically, and emotionally.

Unlike many other Americans in similar circumstances, we have managed to keep our HMO coverage without interruption, paying the full premiums ourselves—something over \$6000 per year. Through occasional short-term work assignments, good luck, and extreme prudence, we somehow have been able to do that, one month at a time. Last year our HMO premiums equaled about half our total 1040 income.

America deserves the kind of private health care provided to Jamie by HCHP. From our experience, HCHP:

Efficiently managed both care and costs;

Provided access to state-of-the-art treatments and first-rate outside specialist;

Slashed our paperwork dramatically;
 Allowed flexibility to select—and change—our own doctors and clinics; and
 Provided us with both alternatives and an equitable appeal process for special
 problems all of which serve us today as Jamie nears full recovery.

We all have to be our own advocates to get the best care anywhere. We've had to fight for Jamie at innumerable turns in the road. Nevertheless,

Without the Harvard HMO plan,
 Without the miracles that enabled us to pay our premiums when unemployed,
 Without finding alternative means of to get the long-term care Jamie required,

Without the flexibility to choose among HCHP's own doctor's and centers and to go outside that system when necessary. we would have been bankrupt, Jamie might still be paralyzed and he would almost certainly have been permanently handicapped and a life-time Medicaid patient at enormous taxpayer expense.

Our best HMO coverage came through HCHP's own centers, those managed directly by Harvard Health. Services through a semi-independent medical group were distinctly inferior. The contracted medical group that we started with did not work for us over the long haul, just as the April 5th Newsweek reported a similar PPO did not work for the Tostison family cited in that article. (Newsweek: April 5, 1993: 34)

Of even greater concern, we found that our HMO plan, like many other HMO's and insurance plans, provided us with only limited coverage for longterm care needed for Jamie's full recovery.

Finally, we were, and continue to be, chained by pre-existing condition to our HMO in the Boston area when all the jobs in my field have gone south.

While good HMOs can play a positive role in providing health security, it is essential that provision be made nationally for catastrophes, including unforeseen instability to keep up with premium payments, so that those who pay their own way are not left out in the cold in the case of crisis. This means:

Coverage for families without work, enabling us to keep our HMO coverage,
 Long-term care for catastrophic illnesses, accidents, and old age,
 Portability, so we are not chained to a job, insurer, HMO, or geographic area.

If you, Gentlemen, and President and Mrs. Clinton can help turn the economy around and put Americans back to work, and if you can find a way to help us carry our health care costs in the face of adversity, Jamie and the rest of us can get through these hard times without devastation. If that cannot be done, we are all in deep trouble—placing an even greater cost on the over stretched national budget, risking social disorder, and an even greater national debt.

Senator DODD. Thank you, Mr. Chairman.

I gather we did not have opening statements, so I would ask unanimous consent that my opening statement be included in the record.

The CHAIRMAN. All the opening statements will be included as if read.

[The prepared statements of Senators Dodd, Mikulski, Thurmond, and Durenberger follow:]

PREPARED STATEMENT OF SENATOR DODD

I would like to welcome you to today's hearing of the committee on Labor and Human Resource on managed care and the health insurance industry. I would like to extend a special welcome to our three witnesses who are from my own State of Connecticut—James McLane of Aetna Health Plans, Kathleen Franklin, a nurse who heads preventive care for CIGNA, and Robert Tedoldi, of Bolton, who will testify for the National Association of Life Underwriters.

Our topic today is a charged one, and much rhetoric has flown around it during the last few weeks. I hope that today's hearing will afford us an opportunity to rise above the sound-bites and do something we don't do enough of around here: Listen, listen to

those who deal with these issues on a day-to-day basis and see what lessons we can draw from their experiences.

I say this both as Senator from the State of Connecticut, which is home to many of the Nation's insurance companies, and as an original cosponsor of the President's health care reform legislation.

One of the people we will hear from today is someone whose family has had direct experience with managed care. He is not an executive, not an activist, not an academic. He is a real person whose positive experience with this kind of medical care may shed some light on this issue.

IMPORTANT POINTS

I hope this hearing will also serve to illustrate some important points. The first is that the insurance industry is not a unified bloc that speaks with one voice. As we will see, different companies have very different perspectives on the reform process.

INNOVATION AND MANAGED CARE

Another fact I think today's hearings will illustrate is that many of the large-scale reforms President Clinton hopes to achieve through his health care initiative are being successfully field-tested today by managed care companies and health insurers.

Managed care programs are holding the line on costs; health maintenance organizations are emphasizing preventive care; and many companies are encouraging innovative treatments that are more convenient for patients and less expensive for society.

Managed care companies have also created innovative prenatal care programs and are making progress in cutting down on the red tape that surrounds much of our health care system.

CONTROVERSY OVER ADVERTISEMENTS

Finally, I think we may see today that members of the managed care and insurance industries are committed to reform. There has been a flurry of controversy during the last several weeks about television advertisements critical of the President's health care reform plan. I have certainly been troubled by the tone of some of these commercials, because I think that rather than promoting constructive debate they are provoking fear.

Nonetheless, I believe that the response to these advertisements has also been unfortunate in that it tries to paint all insurers with the same broad brush and argue that all companies are resistant to any kind of reform.

COMMITMENT TO REFORM

This impression, I would suggest, is skewed, and I would point to this advertisement from The Alliance for Managed Competition as a case in point. There has been a great deal of attention paid to advertisements critical of the President's reform initiative, but haven't seen much discussion of this page. (Hold up ad and read from it.) This group represents some of the largest health insurers in the United States, including some we will hear from today.

BUILDING BRIDGES

As we continue with this process, I hope we will remember how tremendous the stakes are. We are talking about overhauling one-seventh of the biggest economy in the world. We are talking about reforming the way all Americans receive services that can often determine whether they live or die.

The task before us is simply too great for us to engage in name-calling and petty politics. That would be a recipe for failure. We should not create bogeymen and pin all the blame for our current health care problems on them. That would be incredibly short-sighted. The way to achieve real reform lies not through creating enemies but through building bridges.

Although we will certainly have sincere disagreements about how best to proceed, I hope we will all strive to keep the plane of debate on a constructive and reasoned level. I think that the American people deserve no less.

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning Mr. Chairman, and witnesses. I am very pleased that we are holding this hearing today, because I don't think we have heard enough from the insurance industry, clearly a critical player—and in some respects a much maligned player—in our Nation's health care delivery system.

This industry has gotten something of a bad rap in the health care reform debate. From all of the rhetoric you would think that the exploding costs of health care can be laid at the feet of the insurance companies.

Of course the reality is that much of what has driven the cost of health care up—an aging society, new technology, defensive medicine, growth in the number and type of health services Americans use, and so forth, is clearly outside of the control of these people.

And there are important steps the insurance companies have been taking to help with this problem, working to simplify billing and claims processing, building the managed care concept in the first place, improving small employer clout in the marketplace . . . the list goes on.

But we have also seen a response to increasing costs from the insurance industry which has resulted in limiting protection to higher risk populations, "cherry picking" excluding people with pre-existing conditions and otherwise pricing certain people out of the market. Virtually everybody is agreed on the need for reform in those areas.

We would be making a big mistake to venture into this arena without carefully listening to those of you with years of experience in this field. You know better than anyone what works and what doesn't.

I know I have some concerns. For one thing I'm worried about complexity and bureaucracy. I'd like to hear what you think about the proposed alliances, and how to keep from depersonalizing our health care system.

I also want to know what you think about the premium caps being proposed. I see the need for cost containment and reform, but I want to be sure we don't throw the baby out with the bathwater.

I'm worried about the effect of caps on services, and the risk of putting caps into effect before cost containment reforms are in place and having their desired effect.

So again, Mr. Chairman, thank you for calling for this hearing, and I look forward to the testimony of these witnesses.

PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman: It is a pleasure to be here this morning to receive testimony on the role of the insurance industry in health care reform. I would like to join my colleagues on this committee in welcoming our witnesses here today.

I am concerned that we do not destroy what is right with our health care system while addressing what is wrong. Let us not forget that our current system insures 85% of our population. We also have the highest quality of health care in the world. Americans will not accept any health care plan if the basic quality of care is diminished.

We must question whether forcing employers of less than 5000 employees and individuals to join exclusive health insurance purchasing groups will address the reforms necessary. We also must question the effect of employer pay-roll taxes to cover health care costs.

While the insurance industry generally does a good job, there is room for reform. We should facilitate the use of a national claim form. One of the many complaints I receive concerning health care is that insurance companies "stall" the process by overwhelming patients, doctors and hospitals with forms. I believe that computer technology will help alleviate much of the excessive paperwork facing health care providers, insurers, and individuals.

Another area for reform is the elimination of pre-existing condition clauses. Unfortunately, many insurance companies seek only the healthiest people to insure. No person should be denied access to health care as a result of a pre-existing illness. However, a person who has access to coverage but declines to take it should not then hold the insurance company responsible.

There is a growing concern among our work force that when a person changes jobs they will not be able to maintain the quality of health coverage they currently enjoy. This inhibits job growth and the mobility of our workers. We need to examine ways to guarantee that when an employee changes jobs, or when an employer changes carriers, there will not be a lapse in benefits nor a waiting period applied because of existing health conditions.

Again, I would like to welcome our witnesses here today. I am hopeful that their testimony will help us to better address the issues surrounding health care reform.

PREPARED STATEMENT OF SENATOR DURENBERGER

The purpose of the hearing today is to explore the role of the insurance industry. This issue is central to successful health care reform as it is primarily the insurance industry that will administer the accountable health plan, the pivotal force in "managed competition". The accountable health plan is the vehicle that ultimately

contains rising health care costs and improves the delivery of health care.

The question I will explore at the hearing today will be this: Why will the requirements of the Clinton Health Security Act defeat the purpose of the accountable health plan? Based on the details of the plan, there are at least two major reasons.

First, there are requirements in the bill that would threatened plan solvency. The cap on premiums would limit growth to CPI plus an additional percentage, which is phased out by 1996. No other nation has kept its health care cost growth to CPI and it is ridiculous to expect that we will be able to as quickly as the Clinton plan demands it.

The budgets imposed on the health alliances, the solvency requirements for accountable health plans, and the imbalance of funds that will flow into and out of the alliances all threaten the ability of the accountable health plan to stay afloat. When plans fall because the money coming into the alliance is less than what is going out, the guaranty fund, meant to ensure payment to providers, is constructed in a way that smacks of another S & L fiasco. It will require government bail out at the taxpayers' expense.

Second, the incentives that would be at work in a free market place will be gone. The role that the employer played, under the Jackson Hole plan, will be changed from that of an active negotiator and innovator to one of a bill payer. The directives in the plan that essentially dictate the price of the plans will give insurers incentives to find ways around the regulations, instead of better ways to manage health care, improve quality and lower prices. Employers and insurers need to be given incentives to be efficient and to offer the highest quality at the lowest possible price. The free market does this best, not government.

Imposing these fiscal restraints top down, instead of letting insurers compete on quality and price, and limiting the role of the employer, brings us one step closer to government rationing of health care, long lines, and poor health care quality—what you get from a government run, single payer system—not a system “managed” by competition.

Senator DODD. I want to thank you, Mr. Chairman, for holding this hearing and hopefully breaking through this myth that all insurance companies are exactly alike.

I am pleased to welcome Jamie McLane, who is here to testify this morning on behalf of Aetna Health Plans and the Alliance for Managed Competition. He is a group vice president for Aetna Life and Casualty and CEO of Aetna Health Plans. I would point out, Mr. Chairman, as well, that he is not a stranger to these issues at all. He served as the executive assistant to the Secretary of HEW, in those days. He was in the White House, on the Domestic Affairs Council Staff, and he was deputy Director of the Cost of Living Council, which managed wage and price controls, from 1972 to 1974. So he has some first-hand experience in the matters we will discuss today.

Next to him, Mr. Chairman, is another Connecticut resident, Kathy Franklin, from South Windsor, who is a registered nurse and director of preventive health services with CIGNA Healthcare. Her career has focused on health education and wellness programs.

Prior to her position at CIGNA, she was the health education program director at Saint Francis Hospital and Medical Center, where she worked for 12 years. She also serves as a member of the Group Health Association of America's childhood immunization work group and is a certified instructor for the National Center for Health Promotion.

We are pleased to have both of these witnesses with us.

I am going to ask as well, Mr. Chairman, that this ad run by The Alliance for Managed Competition be included in the record. We hear a lot about ads run about health care reform. We do not hear about this group—The Alliance for Managed Competition—too often. We should. We are proud of them—Aetna, CIGNA, and The Travelers in my State, and MetLife and Prudential as well are members. They have a different perspective than other groups of insurers, and frankly, I hope people will start to discriminate a bit instead of lumping everyone together. I think this ad says a lot about the success of managed competition. It has been tried, and it is working.

So I would ask that that ad be included as part of the record.

The CHAIRMAN. It will be so included.

[Document follows:]

TOP 10 REASONS...

WHY AMERICANS WILL HAVE MORE CHOICE OF HEALTH CARE PROVIDERS UNDER MARKET BASED MANAGED COMPETITION.

10.

Americans will be able to change providers within their plan.

9.

Americans will be able to switch plans.

8.

Americans will be able to seek providers outside their plans.

7.

Americans will be able choose from a menu of plans.

6.

Americans will be able to have a "primary care physician" who will advise them about the selection of other providers within their plan.

5.

Americans will have real information — a report card — about "patient satisfaction" concerning providers within their plan.

4.

Americans will have real information — a report card — about costs when they choose a plan.

3.

Americans will have real information — a report card — about the success of medical treatments when they choose a plan.

2.

Americans will no longer have to choose health care providers out of a phone book.

1.

The essence of managed competition is informed consumer choice.

REAL CHOICE. CASE CLOSED. LET'S MOVE ON.
Let's move on in a bipartisan effort to achieve health care reform.

THE ALLIANCE FOR MANAGED COMPETITION

Providing Health Coverage for 60 Million Americans

AETNA

CIGNA

METLIFE

THE PRUDENTIAL

THE TRAVELERS

The CHAIRMAN. Mr. McLane.

Mr. McLANE. Thank you, Senator Dodd, thank you, Mr. Chairman.

I really feel at home. My wife is a nurse, and I am sitting next to a nurse today; my name is Jamie, and I am sitting next to Jamie Odell; and I happen to be chairman of Outward Bound USA. So I really feel at home in front of you here today.

I also appreciate the opportunity to testify on health care reform and on the role that managed care companies such as the Harvard Community Health Plan that Mr. Odell was talking about, and Aetna Health Plans, can play in achieving reform.

As Senator Dodd pointed out—

The CHAIRMAN. If I could just interrupt, I do not like these little boxes, but we have a full panel and I know we have a lot of good questions, so we are going to try to do the best we can and ask you to try to limit your statements to about 5 minutes, because we do have some questions.

So we will ask you to use your good judgment on the time.

Mr. McLANE. I understand. You know who I am representing, so I will not spend any more time on that. Senator Dodd introduced us well.

I know that lately the insurance industry has been criticized for opposing reform and retarding progress. Without commenting on the merits of the debate, I want to say emphatically that Aetna and the other members of The Alliance for Managed Competition must be distinguished from those who have voiced strong opposition to fundamental reform.

We believe, and we believe passionately, that the Nation's health care system must change. Structural reform in the system is long overdue.

We support the broad goals of health care reform as articulated by the President. We commend him and the Congress for putting an historic reform agenda on the table for debate.

I think the most important thing that you can do is to get all the issues out on the table and to weigh the trade-offs in your deliberations of legislation.

I believe managed care is working and can and should play a very significant role in the future health care financing and delivery system in this country. I think you heard a perfect example of it from Mr. Odell. I have another example that I would like to include in the record in terms of another child, 6-year-old Allison Rittman, who had leukemia. It was exactly the same situation in terms of a case nurse who took responsibility for Allison Rittman and referred her to the appropriate specialist in Minnesota. This girl happens to live in the South. The University of Minnesota is one of our Institutes of Excellence for this particular type of disease, and managed her case all the way through with, as you pointed out, minimal paperwork or no paperwork, and hand-carried and taken care of through this process.

The type of coordinated care that Allison received I think is part of the revolution that is already underway in the health care marketplace, moving society toward better, more cost-effective health care for more and more Americans. And it is a revolution driven by market forces.

Fifty-one percent of America's employees are now in network-based delivery systems. That is up from 28 percent in 1988—double in 4 years. Enrollment in HMOs is now almost 42 million. HMOs achieve savings of over 27 percent compared to the traditional fee-for-service indemnity plans. And these are not one-time savings.

Even CBO thinks that managed care can save money. It estimates that if everyone with insurance were in HMOs, national health expenditures could decline up to 10 percent in 1992 terms, an \$83 billion cost reduction, which would rise to over \$98 billion with the results of the just-released AMARA study cited a few moments ago.

Managed care saves money. It also contains inherent incentives to encourage prevention—which I think you are going to hear something about from Kathleen Franklin—and provide better and more intelligently coordinated care, which I think the Odells pointed out very well.

For example, in our HMOs, the immunization rate for infants and toddlers is more than 70 percent—over twice as high as the rate in our indemnity plans. Active education programs have increased our pediatric immunization rate in Tampa by 28 percent and decreased C-sections by 14 percent in New Orleans. The same can be said for mammography, and on and on.

Most Americans, according to several surveys, which I think is very important, over 80 percent of Americans, are at least as satisfied with their coverage, their physician, their quality of care in their managed care programs as they were in their traditional programs. And if I heard what Mr. Odell said, he is more happy than he was in his traditional program.

Contained costs and high-quality health care are the direct results of well-run managed care programs, and what we need to achieve in health care reform. I want to urge the committee to ensure that you do not pass legislation that impairs this type of progress, that impairs organizations like the Harvard Community Health Plan, Aetna Health Plans, and others are doing; that you focus on fixing what is broken.

Clearly, we must provide coverage for the uninsured and underinsured. Clearly, there should be portability. Clearly, there should be reformed insurance underwriting practices. Clearly, we have got to get the paperwork hassle out of the system, and the rates of increase in health care costs clearly have to be brought down.

There are just two problems that I see with the administration's proposal that I would just like to highlight; one is premium caps, which I am sure does not surprise you, and the other is the unnecessarily large and overly regulatory health alliances.

As you heard earlier, I ran the wage and price controls in this country for 2-1/2 years, and I could spend all day here—in fact, I testified in front of this committee several times about the damage that price controls were doing to the economy, and there was story after story of that, and I will not go into those at this particular moment. But what bothers me even more is that any type of premium cap or price control will inhibit capital from coming into the private sector, be it the Harvard Community Health Plan, be it Aetna Health Plans, or be it any other health plan that you know.

We are raising money in these private markets, which comes both from Americans and from foreigners, in order to spend billions on what we have to do to develop networks, to develop outcome measurements, and to develop the systems and so on that need to be developed.

Requiring employers with 5,000 employees or less to be part of health alliances requires 98 percent of employers and 70 percent of employees in this country to be in alliances. Many large and medium size companies and organizations, associations, unions today already are applying their creativity and imagination to the problems and have reduced their health care cost increases to single numbers, while ensuring high-quality care for their employees.

Again, I urge that the legislation focus on the problems and that the alliances focus on the problems that small business is having. I suggest that a hard look be given to alliances for companies with 100 employees or less and allow these alliances to work in behalf of their members—not some abstract Government bureau or administrator.

Let me close by saying that The Alliance for Managed Competition believes, and I personally believe, that the marketplace is beginning to and can deliver better health care at reasonable cost to the American people, under a reasonable, noninvasive reform structure. We say bring on fundamental reform, but let it be reform that supports the progress now being made in the private marketplace and fixes what is broken.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. McLane follows:]

PREPARED STATEMENT OF JAMES W. McLANE

Mr. Chairman and members of the committee, thank you for the opportunity to testify today on the issue of health care reform and the role that managed care companies can play in achieving reform.

I am here as a representative of Aetna and The Alliance for Managed Competition. Aetna Health Plans is one of the Nation's largest group health insurers and managed care providers. We provide group health benefits to more than 19,000 employer-customers and, through them services for more than 13 million individuals. Aetna Health Plans has the largest network of providers, with 105,000 physicians and 1,200 hospitals in 42 states. Approximately 4.3 million people are enrolled in Aetna network products, including 2.5 million in 177 PPOs, 1.3 million in 27 HMOs and one-half million in point of service products.

The Alliance for Managed Competition is a coalition with Aetna, CIGNA, Metropolitan, Prudential and Travelers as members. Collectively, these companies provide health coverage to 60 million Americans. In 1992, the AMC companies paid out \$55.8 billion in health benefits.

Changes Needed To System

First and foremost, I want to tell you that Aetna and the AMC believe our health care system must change; this was the purpose for AMC's formation. We strongly support the broad goals of health care reform articulated by the President, and we commend him and the Congress for putting forth thoughtful proposals with bipartisan support. (See Attachment 1 for AMC advertising).

Since its inception, AMC has supported health care reform legislation in this Congress and in the last that would:

- Eliminate preexisting condition limitations and "cream skimming" and "cherry-picking" underwriting practices
- Make coverage portable
- Reduce unnecessary paperwork and hassle in the system
- Establish a standard benefit package
- Expand preventative care

- Reform medical malpractice
- Establish purchasing pools for small business to increase access at reduced cost for all Americans
- Emphasize network-based delivery systems and use of healthcare quality and outcomes measures
- Provide universal coverage

As you know, there is no easy way to meet all the goals for our health care system. But there is a revolution already underway in the marketplace, among employers, individuals, providers and our business that is reforming the system. This is the movement towards managed care. We already see that 51% of employees are in network-based delivery systems, up from 28% in 1988- almost double in 4 years. Enrollment in HMOs has more than quadrupled in the last 12 years—now totaling nearly 42 million individuals. (Foster-Higgins Survey; released 3/93.)

Health care reform can and should expedite these changes that are being made every day by individuals and employers. A number of the proposals before Congress recognize this, including the President's. They do so because the migration to managed care is having a demonstrable impact on health care costs and quality and because consumers like what they get.

Managed Care Saves Money

There is substantial evidence that managed care reduces the cost of medical care.

- According to a recent Foster-Higgins report, released March, 1993, the average cost for an HMO plan is 23% less than traditional health insurance plans. (Attachment 2.)
- Costs also rise more slowly in managed care plans. For example, the same report reveals that premium increases for 1992 were 8.8% for HMOs and 9.2% for all managed care plans, compared to 14.2% for traditional indemnity plans.
- And, at Aetna, over the last four years, the cumulative premium trend for our HMO has been 21% better than the trend for indemnity coverage.
- A November 1992 study in the Archives of Internal Medicine shows that managed care patients had shorter hospital stays and lower costs than traditionally insured patients, with no apparent difference in outcome.
- OPM reports benefits have improved and premium increases have been moderate in FEHBP due to the success of its PPOs.
- A very recent (11/4/93) study commissioned by AMCRA (American Managed Care and Review Association) further demonstrates cost savings for managed care: HMO's achieve savings of 27.1% beyond traditional fee for service. Applied to CBO's study, this 27.1% savings produces a national expenditure savings due to managed care that is 24% higher than CBO's projections (that is, \$15.5 billion more). Contrary to CBO, managed care savings are not one-time savings. (Attachment 3)

The savings for managed care noted above could be expanded if managed care is allowed to flourish under healthcare reform. CBO has estimated that if everyone with insurance were in HMO's, national health expenditures could decline up to 10% (which in 1992 would have represented a reduction of \$83 billion). And if HMO's "were expanded within the framework of managed competition, the potential savings might be larger . . ." (CBO study; May, 1993). Aetna has prepared its own estimates of savings if a managed competition system similar to the Jackson Hole Group were implemented. These estimates show possible new savings of \$290 billion for public and private investment over the next five years. Our analysis with assumptions is included in Attachment 4.

Let's look at an example of particular interest to the federal government. The CHAMPUS Reform Initiative (a five year managed care demonstration project for California and Hawaii military dependents and retirees) produced savings through 1991 of more than \$120 million to the U.S. taxpayer and an additional \$28 million to military families. Clearly, managed care saves money. Aetna is proud to have managed the southern California portion of this contract and recently Aetna was awarded the entire contract starting in February, 1994.

Managed Care Improves Quality

Medical care quality is enhanced in managed care. For example, the immunization rate for children in HMOs is twice as high as such rate in fee-for-service plans. Mammography screening among women age 50 and over is 40.3% in our HMOs, compared to 16.9% for our indemnity plans. Active education programs have increased our pediatric immunization rate in Tampa by 28% and decreased Cesarean Sections by 14% in New Orleans. We are also testing programs that identify "high risk" populations and applying techniques aimed at early identification of illness

and early treatment. Aetna has a program in Chicago that increased mammography rates by 35% and in Cleveland by 30% by providing educational materials to "at risk" members and working with primary care physicians to outreach such patients.

Americans Like Managed Care

Consumers recognize the value of managed care. According to a recent Foster-Higgins report, people covered under HMO plans are at least as satisfied with the care they receive as those covered under traditional plans. Of large employers surveyed, in a 1992 Towers-Perrin survey, virtually all (91%) say managed care is achieving its objective (of sustainable cost reductions and enhanced employee satisfaction) and nearly three quarters (73%) say that employee satisfaction with health benefits is the same, or better, under managed care. And, an Aetna commissioned survey by the polling firm of Mellman and Lazarus (September 1993; Attachment 5) shows that a large majority of managed care network members are satisfied: with their health care coverage (80%); with the quality of their medical care (88%); with their physician (83%); and with the cost (66%).

These findings are confirmed in a just-released nationwide public survey commissioned by AMARA. We note, in particular, that 90.9% of consumers whose health plans require use of a "gatekeeper" rate their quality of care as excellent or good. (Attachment 6)

Role of Managed Care Companies

How does managed care achieve these quality improvements while saving money? We provide members a choice of high quality primary care physicians, selected for their credentials, track record of quality service and geographic accessibility. For example, if you join Aetna's managed care network in the District of Columbia, you'd be one of 22,000 total lives covered by Aetna in D.C. and one of 4,000 covered by Aetna's D.C. HMO. You would have over 950 physicians and 5 hospitals from which to choose. And in the greater D.C. metropolitan area, you could choose from around 4,000 physician/dentists and 27 hospitals.

This linkage to "family physicians," allows consumers to build a trusting relationship, be assured that their doctor knows their full medical history and rely on that doctor to arrange any necessary specialty or tertiary care for them. Depending on the specific plan, members may choose to use other physicians without the consultation of their primary care provider. But most find that relationship so helpful that they prefer to see their primary physician first.

The managed care company assists the doctors in providing the best quality care to their patients by keeping them apprised of data pertaining to their patients' utilization of services, organizing an available network of high quality specialists and institutional providers who provide competitively priced services, and assuring that they are aware of the latest clinical findings on alternative treatment protocols.

Furthermore, paperwork is greatly simplified for consumers and providers.

Finally, managed care systems have a vested interest in keeping members healthy. They cover more preventive services and actively encourage and educate members to lead healthier lives.

As you can see, managed care address the President's principles of security, savings, choice, quality, simplicity and responsibility.

Let me give you an example of how managed care works in real practice. Last year, little 6-year-old Allison Rittman was diagnosed with leukemia. Her doctors and parents decided a bone marrow transplant was needed, so the family traveled from their Alabama home to the University of Minnesota Hospital, home to one of Aetna's Institute of Excellence programs. Our case management nurse, Pam Parker, worked with the family every step of the way, helping with travel and housing arrangements for Allison's mom and dad. Thankfully, the transplant was a success. Now the parents wanted their daughter to leave the hospital as soon as possible. Once again, Nurse Parker was there, arranging for "home" health care near the Minnesota hospital. Finally, when Allison and her young parents were ready to return to their real home in Alabama our nurse continued to assist. Again, home health care was arranged and nurse Parker ensured the Rittmans received proper medical training to provide care for their recovering daughter while she was back in her own bedroom. Today, Allison is doing fine.

Sixteen-year-old Jason Lionette from Texas is another remarkable story. After more than two years on a waiting list for a bone marrow transplant to treat his leukemia, this Dallas-area youth was beginning to lose his long battle with the disease. His tissue was difficult to match, and a transplant was his only hope. Finally, in March of this year a donor was found, but the donor lived in Australia. Our case management nurse and the Baylor Medical Center in Dallas arranged for the bone marrow to be collected and brought to Dallas. But this was expensive.

This nurse, Marelle Matyk, spoke with the company where Jason's father worked, and they agreed to use funds available for non-health benefits to cover the cost. Because Jason lived nearby, money normally used for lodging and transportation was diverted to cover this large expense.

Today, Jason is at home in his own bed recovering. His mother was trained to administer medication at home because Jason continues to require IV drugtherapy.

Both of these cases show clearly how managed care works for patients.

Aetna, other AMC members and many other HMO and managed care companies have revolutionized their fundamental business focus in order to provide managed care. We have prepared a detailed list of these business changes (Attachment 7). Essentially Aetna and others are transforming themselves from group insurance and indemnity companies into managed health care companies. Over the last several years, we have evolved From: selling benefit programs to employers and paying the claims. To: using information to manage medical costs and to ensure high quality health care. From: providing coverage on the basis of risk selection. To: managing health care delivery. From: viewing the provider as an adversary, and micromanaging medical procedures through "inspect and control" procedures. To: working closely with providers as partners, where we respect each other's strengths and work together on total cost and quality management.

We believe that these changes are not only critical to marketplace demand but also critical to achieving the reforms that the President, the Congress and the public want. This is how we see our role in health care reform: providing the infrastructure necessary to achieve essential cost reduction, while maintaining and enhancing quality. We thank Senator Dodd for his public recognition of our success as he recently cites Aetna, CIGNA and Travelers for achieving "on a small scale what we hope to achieve nationwide through healthcare reform—namely, cost reduction and quality control."

Risks to Successful Health Care Reform

There are proposals before the Congress that will build on the growing managed care base, including certain elements of the President's program. However, we are concerned that in two respects the President may be recommending provisions that will undermine his plan's basic managed care foundation.

Our first concern is with premium and budget caps. We understand that the goal of both is to ensure that costs are reduced. But these provisions are fundamentally inconsistent with achieving long term, real savings in our medical system. Virtually all health economists agree that one key to real savings is to reduce unnecessary medical treatments and provide only the services that are proven to work, as documented by outcomes data. Another key is to educate and encourage individuals to be informed purchasers of care. (See Attachment 8 for elements of growth in national health spending.)

Managed care is designed to achieve both. But managed care has not achieved universal market penetration. The revolution is still occurring and any artificial price restrictions will significantly impede its development.

Significant investment is required to build the managed care infrastructure needed for effective health care reform under President's plan and other proposals. Based on extrapolations of our own investment in Aetna's managed care infrastructure in recent years, we roughly estimate that \$93 billion will be needed across the U.S. for managed care companies for new health care facilities, to expand provider networks, for new medical and information technology, to hire/retrain medical staff and to put quality management and member services in place and for required reserves and working capital. (Attachment 9)

The capital required to build this infrastructure will not be available if premium caps are imposed. Today's investors in the health care industry will not continue to put capital in an industry that carries the risk of artificial price restraints. There is real evidence of this in the last year alone. Nine managed care companies lost over \$7 billion in market capitalization over a two-week period (February 4, 1993 to February 22, 1993) in response to reports that price controls were to be imposed. (See Attachment 10)

The market place is already controlling costs and is building to be even more effective in this role. As we stated at the outset, legislation should enhance this capability, not cut it off.

Our second concern is with the unnecessarily large and overly regulatory Health Alliances in the President's plan.

We support pooling individuals and small employers to take advantage of economies of scale in administration and marketing. However, the President's proposal calls for alliances so big (employers with 5,000 employees) and with so much regu-

latory power that the alliances would undermine the very competition that is so essential to the marketplace.

If every employer up to 5,000 employees is forced to join an alliance, health care for the vast majority of the American population would be controlled by such alliances. We are taking about 98% of employers and 70% of employees.

Small-employer alliances would facilitate competition by improving purchasing efficiency, but large-employer alliances would dominate markets, stifling competition and innovation. We would no longer have the benefit of the current efforts of large employers to improve health care quality and cost-effectiveness since employers' costs would no longer be tied to their own experience, but to that of the entire alliance. Also, employees of medium and large employers would be forced to change the health coverage they enjoy today, negating successful past efforts to improve quality and cost-effectiveness.

The proposed corporate alliances will not address our concerns. Based on our analyses and discussions with large employers, many employers above 5,000 will be compelled to join health alliances. These "disincentives" include new financial reserve requirements, new authority for states to tax corporate alliances, exclusion from government subsidies for low income employees and a 1% payroll tax.

The alliances recommended in the President's proposal go way beyond addressing real problems in the system. They seek to "fix" what is not broken—coverage in the medium to large size employer market—and this is precisely what the President has said we should not do. Employees in this market are well served by these plans. Instead, we need to focus on what is broken and remedy it. Let's design health alliances for the small employer. And let's focus on how to encourage and support continuing employer innovation in employee satisfaction, cost and quality management.

We are also concerned about other provisions which would undercut our ability to control costs—such as the President's proposal to allow doctors to collaborate on fee negotiations in spite of antitrust laws.

Conclusion

Thank you very much for the opportunity to appear. I reiterate my opening comments that health care reform is essential and Aetna and the AMC are committed to its achievement. I look forward to a time when everyone will have the protection they need from unforeseen health costs and everyone can make an informed choice about their coverage based on quality, access and cost. I would request that my oral comments and accompanying written statement and attachments be included in the record.

[Attachments to Mr. McLane's statement are retained in the files of the committee.]

The CHAIRMAN. Ms. Franklin.

Ms. FRANKLIN. Good morning, Mr. Chairman. I am Kathleen Franklin, and I am a registered nurse with a bachelor's degree in education. I am director of preventive health services for CIGNA HealthCare.

Before coming to CIGNA, I worked in a community hospital in Hartford for 15 years. Thank you for allowing me to bring my personal view, that of a nurse, to these important proceedings.

As the country's largest investor-owned HMO, CIGNA shares the commitment to the future of America's health system, to preserving quality and controlling costs. We support those reforms that Americans say they want most—assuring quality of care, controlling cost, preserving choice, and expanding access to the uninsured.

Based on our experience and our success, we have no doubt that managed care must be the centerpiece of reform.

I would like to offer my personal perspective on managed care based on my many years in the hospital setting. As a nurse, I attended to people who were diagnosed with high blood pressure, prostate cancer, and other life-threatening illnesses. I cared for women who were pregnant and for families with children. I saw people at their most vulnerable and at their most motivated times. Unfortunately, all too often, I saw them let down by a system that

could not or would not provide the resources to help them make decisions concerning their care and to improve their overall health.

In my judgment, managed care provides such resources, and as such is eminently preferable to the random care which so many people receive under the current system. There are important differences between traditional medicine's focus on treating the ill and managed care's emphasis on broad-based quality care, running from preventive screenings, wellness programs, through individualized programs and follow-up programs.

Our healthy baby program proves how effective managed care can be. It is not unusual for triplets to be born prematurely, leaving those infants with respiratory problems and other physical deficits. They often spend considerable time in the neonatal intensive care unit, generally at enormous cost.

That did not happen in the case of one of our members in Florida. She went into premature labor 24 weeks into her very first pregnancy. Although her doctor would have released her at 30 weeks, our case managers continued that mother's hospital stay for an additional 4 weeks, and she delivered three healthy babies. In addition to the joy that this woman experienced with her three healthy infants, she also was able to go home with her children, and more than \$235,000 was saved through that effective case management decision.

Another area, and one in which I am personally and professionally interested, is preventive care. Uniform preventive care guidelines help to assure quality of life for our members. These guidelines are furnished to members and to providers. They specify when individuals should be getting mammograms, pap smears and immunizations.

The National Council on Quality Assurance, a private not-for-profit independent HMO accreditation body, sets performance standards for preventive health. It has already accredited a number of CIGNA health plans, and we are committed to having all our health plans accredited by 1996.

We use continuous quality improvement to develop more effective medical management of our pediatric asthma patients. Asthma is a major cause of pediatric mortality. A cross-functional team developed guidelines on the diagnosis of asthma and developed asthma education programs to help health plan members, school nurses, and community groups. Through the new process, fewer children are now hospitalized for asthma, and physicians can more effectively manage treatment on an outpatient basis.

Time does not permit me to describe the numerous additional ways that managed care can improve the quality of care and the quality of life. The foregoing examples clearly demonstrate, however, the distinct advantages which managed care holds for individuals over the random and disjointed care available in the traditional health delivery system.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Franklin follows:]

PREPARED STATEMENT OF KATHLEEN L. FRANKLIN

Mr. Chairman, I'm Kathleen Franklin a registered nurse with a bachelors's degree in education. I've been in the health care field for fifteen years. Before coming to CIGNA, I worked in a community hospital in Hartford, Connecticut. Currently, I'm director of preventive health services for CIGNA HealthCare. On behalf of CIGNA HealthCare, thank you for allowing me to bring my personal view—that of a nurse's—to these important proceedings.

Before I tell my story, let me tell you a little about CIGNA. As the country's largest investor-owned HMO, CIGNA shares the Senate's commitment to the future of America's health care system, to preserving quality and to controlling costs. CIGNA supports and is working for those health care reforms that Americans say they want most: assuring quality of coverage, controlling costs while maintaining quality of care, and expanding access to the uninsured.

You have heard or will hear compelling testimony from others regarding managed care's benefits and limitations. But you've also heard other testimony that may lead you to ask: "Can managed care save money on a sustainable basis overtime. And, if so, what effect will managed care have on the quality of care people receive?" Based on my experience and our successes at CIGNA, we have no doubt that managed care can and should be the centerpiece of reform.

I would like to offer my personal perspective, based on 15 years of working in a provider setting, attending the ill and seeing these people at their most vulnerable. Medicine has historically focused on treating ill patients. If we are to gain control of our health care costs and provide care that meets our patients needs, we need to provide better tools for adding value and assuring quality of care.

CIGNA, as a managed care organization is doing just that. And I'd like to cite some examples today. First, adding value.

One good example of the way managed care adds value is the CIGNA Healthy Baby program. It is not unusual for triplets to be born prematurely, leaving the infants' with respiratory problems and other physical deficits. Premature infants often spend considerable amounts of time in Neonatal Intensive Care Units, being released only after accumulating health care charges often totalling six figures. That did not happen in the case of one of our plan members, a 26-year-old Florida mother. She went into premature labor 24 weeks into her very first pregnancy. The anxious mother-to-be was kept in the hospital until her condition stabilized. Although her doctor would have approved the patient's release at 30 weeks gestation, CIGNA case managers wanted to continue the mother's hospital stay for an additional four weeks until she could deliver three healthy babies to term. In addition to the joy for this first-time mother with her three healthy infants, there were no long-term medical problems, and more than \$235,000 was saved through effective case management decisions.

CIGNA's commitment to better prenatal care is not new. In April 1992, CIGNA joined with the National Commission to Prevent Infant Mortality, the Washington Business Group on Health and the American Academy of Pediatrics to hold a national summit on infant health. The conference galvanized private and public sector policy makers to take action—in the workplace and in the community-at-large—to reduce infant mortality. The national summit was followed by local conferences in Tampa, Phoenix, Baltimore, Chicago and Boston. Dallas will be the site of the sixth local summit, to be followed by special conferences in Cleveland, Columbus, Los Angeles and Salt Lake City through 1994.

A study by the Harvard School of Public Health, conducted under a grant from CIGNA HealthCare, produced some startling statistics. U.S. employers spend more than \$5.6 billion annually for health care associated with poor birth outcomes. Even among mothers with health insurance, one of every 22 infants is born with severe health problems.

These tragic statistics, and the human suffering behind the numbers, can be significantly reduced with adequate prenatal education programs and effective case management during pregnancy.

In Greater Dallas, Texas, the 12-passenger MomMobile helps young children and very high-risk pregnant women get to the doctor or clinic for prenatal appointments, well-baby checkups and infant acute care. This unique outreach program operates with a grant from CIGNA Foundation to the North Texas March of Dimes.

In Baltimore, the Healty Generations community-based program conducts aggressive outreach to locate pregnant women in the Brooklyn Park area. A community health nurse and social worker operate as a team with women and high risk infants to link them with primary care providers. The innovative program ensures that the poorest women have access to prenatal care, as well as intervenes with other risk

factors such as poor nutrition, substance abuse, inadequate housing and domestic violence.

In New Mexico, we're working in remote areas to reduce the tragedy of children who don't get necessary vaccines. Albuquerque's Lovelace Medical Center, a CIGNA company, operates a mobile immunization program, which is endorsed by New Mexico's First Lady, Alice King, as a public/private collaboration that should be pursued in every state. As far as can be determined, the Lovelace Immunization Program is the first statewide, corporate-sponsored immunization outreach program of its kind.

Managed care isn't just good for people—it's the right answer for companies, large and small. A Westbury, New York commercial collection agency found that managed care enabled them to maintain and improve overall employee benefits while halting continued escalation of health insurance premiums, which had climbed to 24 percent of payroll. Because of the age of its 80-person workforce, the employee-owned company was laced with a 1993 premium increase of 21 percent. As a solution, the company chose a single, flexible managed care plan which allows employees to use any doctor or hospital they wish, but offers a higher level of benefits if they use health care providers within the CIGNA network.

Unlike their former indemnity coverage, the flexible managed care program emphasizes wellness. In fact, most employees had not previously undergone a yearly physical because of the \$300 health plan deductible. Under the new plan, the company reports that more than 90 percent have seen a primary care physician, and workers are happy with their network doctors. Company surveys show that 87 percent use in-network providers or hospitals, despite having the out-of-network option.

As for cost savings, the company is projecting a 17 percent premium savings—or \$90,000—over their previous indemnity plan. With this savings, the company is contemplating providing employees with additional benefits.

One of the largest organizations using managed care for its entire workforce is Pacific Bell, with 52,000 active employees and 41,000 retirees. Pacific Bell's medical benefits costs had been increasing at 13 to 15 percent a year through the 1980's, threatening the company's competitive abilities. PAC Bell decided to treat health care purchasing decisions like any other procurement-based on accountability for financial results, bid specifications, price guarantees and service levels. In 1991, Pacific Bell scrapped their menu of four indemnity plans and 10 HMO's (down from 23 HMO's in 1983). Financial analysis showed the existing medical plans not only failed to control costs, but were incompatible with Pacific Bell's culture, which required purchasing decisions to be made on a cost-effective basis with measurable outcomes.

The company found that a guiding principal of managed care is that medically appropriate, cost-effective health care will increase quality (based on treatment outcomes and patient satisfaction) for all participants while decreasing unnecessary costs. In 1991, the first year of full managed care, Pacific Bell avoided \$20 million in additional health care expenditures. Per capita increases were only four percent for the first two years of the new program, compared with ten percent per year from 1987 to 1990. The projected increase over the next several years is significantly below that of industry trends and of the company's previous experience.

Let me address an area, in which I am personally and professionally interested—the questions of preventive care, wellness and the overall impact of managed care on quality.

Uniform preventive care guidelines is another area in which I am working to assure a healthy quality of life for our members. Each of our healthplans have been given preventive care guidelines which are consistent with recommendations of the American Academy of Pediatrics and the Preventive Services Task Force of the U.S. Department of Health and Human Services. The guidelines communicated to members and providers outline when members should be getting mammograms, pap smears and immunizations for them and their children. The National Council of Quality Assurance, a private, not-for-profit independent HMO accreditation body, sets performance standards for preventive health care. It has already accredited a number of CIGNA Healthplans, and the company is committed to certifying all healthplans by 1996.

Asthma is the most frequent chronic illness in children and continues to be a major cause of pediatric morbidity and a major contributor to rapidly rising hospital costs. Continuous Quality Improvement (CQI) is being used successfully at CIGNA to develop more effective medical management of these pediatric asthma patients. A cross-functional team developed guidelines on the diagnosis of asthma, and developed asthma education programs for CIGNA Healthplan members, school nurses and community groups. Through the new process, fewer children are now hospitalized for asthma, and physicians can more effectively manage treatment on an out-

patient basis. Beyond the benefit to the patients and their families, reduced hospital stays have saved \$1.3 million.

As a medical professional, I know that good decisions result from better information and data available to both providers and members. In more and more cases, this allows an informed patient to share in the decision making on their treatment. Additionally, by tracking data, we can monitor clinical outcomes and establish critical decision factors about the most successful treatment protocols. I point this out because most health reform proposals envision a future in which statistics gleaned from Accountable Health Plans will provide the data to design better and more cost-effective treatments. CIGNA has invested more than \$1 billion in building managed care networks and in the associated technological capabilities. When the health care system is ready for comprehensive monitoring and analysis, it will be a short step for CIGNA—not a great leap.

We have found that managed care not only controls costs, it can and does work to promote healthier Americans who live longer, more productive lives. Managed care goes beyond providing care in the most appropriate and familiar setting. All across the country, CIGNA is setting up systems designed to monitor each patient's well-being and track their progress. In short, it's an activist approach to medicine and overall wellness.

It should be clear by now that managed care is not a magic formula for the future, but a proven way of delivering more effective, more satisfactory health care while reliably holding down costs. CIGNA is committed to assisting the process of national health care reform, preserving quality and choice for patients and delivering an honest, measurable health care product for those who pay the bills.

Mr. Chairman, I'd again like to thank you for this opportunity to discuss managed care's ability to increase quality and add value to America's health care.

The CHAIRMAN. Ms. Nichols.

Ms. NICHOLS. Thank you, Mr. Chairman.

My name is Sara Nichols, and I am an attorney with Public Citizen's Congress Watch, which is the legislative advocacy arm of Public Citizen. I am here this morning to speak to you about managed care, and I want to make clear that the comments that I make about managed care are not quarrels with managed care as a part of our health delivery system. I myself am a product of managed care. I grew up in the Kaiser Permanente system out in California and found it to be pretty much to my liking. But I am focusing on managed care as a building block for reform, the structural reasons why we are troubled with it. And we are focusing on the rule and not the exceptions.

I would like to focus on three major points. One is why we object to managed competition in general as a way of approach for reform, very briefly; and then focus in on the increased corporatization of health delivery in this country, in particular as caused by the increase in managed care and the effect that that has on the consumer; and then look at managed care itself and the incentives that it provides to the system and the way in which that actually negative affects the consumer in some instances.

Very briefly, we have looked very closely at managed competition in its many forms, and we find it to be very much not in the interest of the consumer as a way of reforming the health care system. Instead of removing a layer of bureaucracy, which is the private health insurance industry, it adds on top of it another layer of bureaucracy, the health alliances. And managed competition is based on the notion that the consumer is responsible for the high cost of health care; the consumer is driving up health care, and we have to expose the consumer to the real cost of health care in order to bring it down. And it is not the consumer's fault. In fact, in this country, we go to the doctor less than any other industrialized Nation on earth, and so to focus on that will not work.

President Clinton has to his credit spent hundreds of pages in the Health Security Act trying to lessen the anti-consumer effect of managed competition structure, and that is a very noble effort, but it cannot work, and we think that that is an impossible road to go down, which is why we support a single-payer system. We support in particular the American Health Security Act, Senate bill 491, introduced by Senator Paul Wellstone along with two other members of this committee, Senators Paul Simon and Howard Metzenbaum.

I want to focus specifically on the increased corporatization of health care, which has been occasioned by more and more managed care in our system. The past 10 years have seen an unprecedented growth of managed care in our health care system, and it has corresponded with rising costs and tremendous costs in our health care system.

We have also seen just recently a tendency toward for-profit HMOs over nonprofit HMOs. From 1986 to 1989 alone, we jumped from 50 percent of the managed care being for profit to 66 percent—a big jump. And that profit that is being earned in the for-profit system is often being earned at the expense of care and at the expense of the consumer, notwithstanding some of the excellent examples of care that we have heard about today.

One of the best examples of that is in advertising and marketing costs that for profit HMOs have. For-profit HMOs spend much more than not-for-profit HMOs. A study in New York City recently found that U.S. health care spent \$12 million on advertising and marketing costs, which was nearly 20 percent of their total budget for health care going to advertising and marketing. In the city there, they were spending about \$55 a person in for-profit HMOs for advertising and marketing versus \$10 a person in not-for-profit.

Managed competition of course is just going to accelerate those expenditures because the name of the game is getting more enrollees into your plan within a given health alliance, and advertising and marketing costs are going to skyrocket under that system, and that will, of course, divert money away from care.

Another very troubling trend in the increased corporatization of managed care is the concentration that it has created into the hands of a few companies. The 10 largest managed care companies serve 44 percent of the national enrollment in HMOs. These include, of course, The Alliance for Managed Competition that we have heard about this morning—Aetna, Prudential, MetLife, The Travelers, and CIGNA.

Managed competition, of course, is just going to increase that trend toward a few companies earning more and more, because those are the only companies that are well-placed to jump in and serve the increased needs in the newly created health alliances with so many consumers who are going to go into managed care.

Our concern is that this will not translate so much into managed competition as a managed cartel, which will be a few large companies who are acting, as most oligopolies do, not to bring down prices but to actually raise prices so that the pie is enlarged, and they each have a bigger piece of it, as opposed to the kind of healthy competition that you would need many, many players in order to actually bring the costs down.

The insurance industry in particular is used to this type of behavior because it has been exempt from the antitrust laws for over 50 years. And we are afraid that that kind of culture of acting in lockstep will inhibit the goals of managed competition to bring costs down.

Another worry of ours, and I think this is a very practical concern, is the health alliances. Who is going to staff them? They are going to have tremendous needs for data collection and actuarial and all sorts of people to work in those health alliances all over created. Well, the most likely place for the workers to come from is from the insurance industry itself. In fact, Ira Magaziner has suggested that that is one place where some of the smaller insurance companies, people if they were put out of business under managed competition, could go to work.

We already see insurance industry domination of a lot of State insurance commissioners and regulation, and we are very worried that we would see this with the health alliances if managed care were used as the basis for reform.

The CHAIRMAN. I will give you about another minute.

Ms. NICHOLS. OK.

Very, very briefly, we also think that while managed care and its part in the delivery system often does produce excellent examples of care, there are other ways in which the structure of managed care is anti-consumer. Consumer satisfaction has actually been shown in at least a couple of studies. A recent study Johns Hopkins did in the Journal of the American Medical Association showed that less than half of the people in HMOs rated their care as excellent, versus 65 percent in independent practices; and the utilization review, which is the heart of managed care, may deter as much necessary as unnecessary care. And it is not clear that the expensive bureaucracy there saves enough money to justify looking over each doctor's shoulder that way.

All of this might be justified if there were tremendous cost savings in managed care, but we do not think that the evidence has shown that managed care would produce more than an initial cost saving.

So in conclusion, this increased corporatization of managed care worries us because of the increased concentration in the hands of a few companies, the extent to which they may dominate health alliances, and the way in which a for-profit, market-driven system acts to exclude consumers or to make its profit at the expense of care. We think the only plan that can really serve the American people and consumers well is a single-payer plan. And I should hasten to point out that managed care can exist within a single-payer system, but it would only thrive if the consumers, who have full choice within a single-payer system, choose to go to those managed care facilities.

So let us see real competition as we would have in a single-payer system, between doctors and plans on the basis of quality and efficiency, instead of between plans on the basis of price.

Thank you very much.

[The prepared statement of Ms. Nichols follows:]

PREPARED STATEMENT OF SARA NICHOLS

I. INTRODUCTION

Thank you Chairman Kennedy and the members of this committee for allowing me to testify today.

My name is Sara Nichols and I am a staff attorney for Public Citizen's Congress Watch, the legislative advocacy arm of Public Citizen. Public Citizen is a national consumer organization with over 160,000 members nationwide. I am here to speak to you today about managed care, who controls it, who benefits from it and because of this, how would it affect consumers if we use a rapidly increasing amount of managed care as the basis for reforming our health care system?

My task today is to lay out for you the structural reasons that Public Citizen is troubled with the use of managed care as a building block for reform. It is a primary reason we oppose managed competition, and favor instead, a single-payer system that does not rely on managed care as the route to reform. We understand that there are excellent managed care facilities in this country, such as some of those represented on this panel. I myself was quite satisfied growing up in the Kaiser Permanente system of California. And we can identify many problems with traditional fee-for-service medicine. Our concerns are not with the exceptions, but with the rule.

Public Citizen has examined managed competition closely in all its various forms and we are opposed to it. We find the structural basis for managed competition to be anti-consumer and consider it impossible to produce reform using that structure. The flaws of managed competition are the same whether in the most public, government-controlled version, the pure market-based version, or whether the version is somewhere in-between like President Clinton's plan.

Among its other problems, instead of removing a layer of bureaucracy from our health care system by moving to a single payer which replaces the inefficient private insurers with the government as the sole payer of health claims, managed competition mandates for most of the population two new layers of bureaucracies between the patient and doctor: the health alliance, and the managed care bureaucracy.

Likewise, the noble goals of the President's health care plan are subverted by the anti-consumer structure he has chosen. Unfettered use of health care services by consumers is not the reason our health care system is so expensive. In fact, we go to the doctor in this country less than any other industrialized nation on earth. So to design a system based on deterring consumers from seeking care won't work and hurts consumers rather than helping them. In short, we do not like managed competition because, by its very nature, it preserves and rewards the most wasteful interests in our current system, namely, the health insurance giants and unfettered private hospitals, while it punishes consumers by blaming them for the high cost of health care.

To the President's credit, the Clinton Health Security Act devotes hundreds of pages to put elaborate mechanisms in place which lessen the cruel effect of managed competition on the consumer. But this exercise is a waste of time because it is an impossible task. The only known way to achieve our shared goals of universal coverage, choice of provider, simplicity and security is through a single payer system. This is why we support the American Health Security Act, S. 491, introduced by Senator Paul Wellstone, along with two other members of this panel, Senators Howard Metzenbaum and Paul Simon.

The two main points I wish to make about managed care today are as follows:

A. The delivery of medical care in America is moving away from a closer relationship between doctors and patients to one of corporate mediation of the doctor-patient relationship. Over the past ten years, enrollment in all forms of managed care plans has more than quadrupled, rising from 10.2 million enrollees in 1982 to 41.4 million enrollees in 1992.¹ The trend toward increased managed care in this country is a trend toward corporate and, in particular, insurance domination of health delivery. Managed competition would greatly accelerate that trend, assuring corporate rather than consumer and provider control of medicine. While more people are members of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Individual Practice Associations (IPAs) than ever before, the response of consumers to the quality of this medical care has been mixed, at best. The fundamental basis for managed care is that a health plan monitors, manages, and controls the access to health services to constrain costs and limit unnecessary hospitalizations and procedures. While the aims of managed care are laudable, as con-

¹ Patterns in HMO Enrollment, Group Health Association of America, 1993

sumers, we are concerned that delivery of care in this manner may sometimes be at odds with the quality of medicine consumers receive. As such, while managed care may be a useful part of our health delivery system, it may not be sufficiently successful to warrant the virtual mandate by managed competition for all Americans to join managed care facilities.

II. CORPORATIZATION OF CARE

A. For-profit HMOs Are Growing

Between 1986 and 1989, corporate ownership of managed care plans surged from 50% to 66% nationally, according to research by Marion Merrell Dow.² The big insurance companies like Aetna and CIGNA, for-profit enterprises like Humana, and large managed care firms like U.S. Healthcare are increasingly purchasing or managing local managed care plans and facilities.

A recent study by Marion Merrell Dow found that 21 of the 25 fastest-growing HMOs were for-profit, and that the Big Eight (Blue Cross, CIGNA, Aetna, Travelers, MetLife, Prudential, Humana, and United Healthcare) own 251 of the 562, or 45%, of the HMOs in the country.³ Only these health care conglomerates have the capital to finance corporate takeovers. The rising concentration in the managed care industry of for-profit companies prompts questions of whether such changes produce quality medical care, lower costs, or other desired results of health care reform.

B. Managed care profit may be profiteering

For the past several years the managed care industry has been earning a hefty profit. Both companies and stockholders have gained during the Eighties. In 1990, the HMO industry earned \$1.39 billion before taxes, and in 1991, 82.8% of HMOs were profitable or earned a surplus.⁴ In 1992, the stock values of 16 HMO companies tracked by Furman Seltz Inc. gained 80% on average, some nearly tripling in price.⁵ Between 1989 and 1992, CIGNA had an annual net income average of \$413 million, Aetna \$463 million, Humana \$260 million, MaxiCare \$160 million, Prudential \$202 million, and U.S. Healthcare \$114 million according to SEC records.

The problem with moving toward a for-profit health care system may not at first be obvious. After all, the profit incentive is widely touted as a panacea for the ills of the health delivery system. However, the recent shift toward profit-making in managed care may have actually exacerbated the problems in our system, diverting dollars from care to overhead. To date, the market-driven health care delivery system has been unable either to control costs or guarantee access to care. This is not surprising, since for-profit health care delivery tends to restrain delivery of services to maximize profits.

The insurance companies, for example, earn profits by paying less in claims than they receive in premiums. To optimize profits, insurers have increased the costs of their products and limited their willingness to pay for and cover services. The companies have traditionally gamed the system by excluding previous conditions, canceling coverage for the seriously or chronically ill, and cherry-picking the healthiest customers.

Even under a system of mandated coverage it appears likely that insurance companies will exclude consumers to generate earnings. Bob Hunter, the former President of the National Insurance Consumer Organization (NICO), recently appointed the Texas State Insurance Commissioner, reports that in states where auto insurance is guaranteed, like California, insurers avoid the inner cities. They claim to "lose" applications, and say they are unable to "find" their Spanish forms.⁶

There is nothing to indicate the market forces at work in the managed care industry will behave differently. Advertising and marketing costs, for example, are the engine of competition in managed care. To encourage consumers to "vote with their feet," firms market their products and aggressively advertise their services.

But for-profit enterprises appear to spend much more on advertising than not-for-profit firms. These marketing costs represent funds which could be spent instead on delivery of care. In New York, U.S. Healthcare spent more than \$12 million on marketing in 1991, amounting to 19.1% of what it spent on hospital care. On average, for-profit firms in New York spent \$55.83 on advertising per member compared to \$10.86 spent by not-for-profit groups in 1991.⁷ The marketing costs incurred by

² For Profit HMOs: Unmanaged costs, Public Citizen Health Letter, October 1991

³ Marion Merrell Dow, *Managed Care Digest*, HMO Edition 1993.

⁴ *Business Insurance*, December 15, 1992

⁵ *Business Week*, July 12, 1993

⁶ NICO Newsletter, vol. xi, nos. 3 and 4, May through August, 1993

⁷ "Vital Signs: What the HMOs Don't Tell You That You Need To Know," City of New York Department of Consumer Affairs, April, 1993

for-profit firms generate more enrollees, but also divert money from providing necessary care.

Certainly, any tendency to devote an increasing percentage of overhead to advertising and marketing costs would only be accelerated in a managed competition-based system where HMOs must convince not only employers, but individual consumers, to enroll in droves. Advertising and marketing costs would be one of many factors in managed competition driving up the cost of care rather than bringing it down.

C. Lack of cost-savings

The size of the profit in the for-profit managed care industry calls into question the quality of care in the facilities and networks. Moreover, since there is little indication that managed care is keeping over-all costs down, the profit may be at the expense rather than for the expense of providing care.

Recent studies from the GAO, CBO, and the Health Care Financing Administration have shown no overall savings from managed care. An A. Foster Higgins survey found that for 48 per cent of employers managed care premiums were as high or higher than indemnity premiums. While high profits, if they coincided with cost controls and high medical quality, could be heralded as a success of the market-based health care system, the reverse is true here. High profits coincide with rising costs leading one to the conclusion that the companies are not only profiting but profiteering at the expense of the consumer.

D. Concentration in the HMO Market

Although enrollment in managed care plans is steadily increasing, a few larger firms are controlling the majority of the managed care market. The ten largest managed care companies serve 44.1% of the national enrollment.⁸ These firms wield enormous market power, have a steady stream of income from their plans, and are shaping the future of American health care delivery. Five of the ten largest managed care enterprises (Aetna, CIGNA, Kaiser, MetLife, and Prudential) were participants in the influential Jackson Hole Group which helped to design managed competition proposals.

President Clinton's managed competition plan is intensifying the flight towards managed care. Along with the insurance companies, teaching hospitals and for-profit hospitals are creating managed care networks or expanding the ones they have. Recent headlines include "Clinton's Health Plans are Likely to Step Up the Switch to HMOs,"⁹ "Health Industry is Moving to Form Service Networks,"¹⁰ "HMOs See Glory Days Under Clinton,"¹¹ and "Managed Competition May Benefit Chains."¹² The Business Insurance prediction after the '92 presidential election was bullish, writing, "[a]n already thriving HMO industry could be a big winner if the health care delivery is overhauled as promised by President Clinton."¹³

The largest insurance company-owned HMOs are spread out across the nation, with many plans in many states. As of April, 1993, CIGNA owned 42 plans in 27 states, Prudential owned 28 plans in 18 states, Aetna owned 25 plans and manages an additional 3 plans in 19 states, MetLife owned 14 plans in 14 states, Travelers owned 9 plans in 9 states,¹⁴ Humana owned 17 plans in 10 states, and U.S. Healthcare owned 7 plans in 6 states.¹⁵ A September, 1993 study by Marion Merrell Dow shows that all of these companies except Aetna own even more HMOs today than they did in April, with MetLife growing from 14 plans to 25 in that short time.¹⁶ Under managed competition, it is almost exclusively companies like these who will be able to move in to fill the needs of the new system. This will virtually assure domination of the managed care system by an oligopoly, rather than a true competitive field.

Dominant among the fastest-growing owners and operators of managed care facilities and plans are the large insurance giants, Aetna, Metropolitan, Prudential, the Travelers, and CIGNA. The general trend towards managed care, as accelerated by the political possibility of managed competition, dramatically shifts insurance companies from processing claims and bearing the risk of loss to assuming near total control of the health delivery system as the owners and operators of HMOs.

⁸ Group Health Association of America, Patterns in HMO Enrollment, 1993

⁹ Wall Street Journal, May 18, 1993

¹⁰ New York Times, August 21, 1993

¹¹ Business Insurance, December 15, 1992

¹² Modern Healthcare, January 4, 1993

¹³ Business Insurance, December 15, 1992

¹⁴ Group Health Association of America, Patterns in HMO Enrollment, 1993

¹⁵ Group Health Association, 1993 National Directory of HMOs, June 1993

¹⁶ Marion Merrell Dow, Managed Care Digest, HMO Edition 1993

In the traditional indemnity insurance market, the insurance industry's exemption from antitrust laws has tacitly permitted collusionary pricing schemes. The increased concentration of the managed care market, rather than generating intense competition between a few players, is instead likely to create an industry oligopoly. This "managed cartel" will have incentives to increase prices rather than lowering them. In this manner, they can enlarge the health care pie, securing each of them a bigger share of it. Naturally, this behavior will tend to raise the cost of health care, rather than lowering it.

E. Corporate and Insurance Domination of Health Alliances

While the concentration of the managed care industry poses problems to Americans today, under the potential managed competition of tomorrow, the larger, wealthier firms will increasingly dominate local health care delivery. The proposed health alliances, which would monitor and regulate health plans, will have a giant task in controlling managed care plans owned by a handful of mega-corporations. The volume of data collection required to provide adequate oversight alone is enormous. To produce sufficient information for consumers, alliances will have to collect information on a wide variety of indicators, from quality to cost.

This task could prove impossible. The Federal Health Benefits Plan has a similar duty to provide information to its members on price and service and has been unable to release understandable information to enrollees. Because of the difficulties of this task, the reality is that the Office of Personnel Management, which has never helped to provide quality and cost information, has merely published the information the insurers provided without providing independent analysis or compilation.¹⁷

The actuarial, medical expertise, accounting, and statistical needs of the alliance will also have to be filled, and it is certain that to do so, the alliance will have to turn to the insurance industry for help. We expect that the data and staffing needs of the Alliances could only be fulfilled by people from the insurance industry. Even *Ira Magaziner* has said some of the staff could come from the small insurers forced out of business by managed competition. Already, insurance companies have a large influence over state regulators, and since health alliances will need the cooperation of the industry, there is a real risk that the alliances could become industry-dominated.

F. Citizen input

Though we fear industry domination of health alliances is virtually inevitable, there are some protections worth instituting, whether in a single payer or managed competition system. At a minimum, consumers need to have a strong voice to combat industry's demands. Independent, private sector health watchdog groups, which would be voluntarily-funded and citizen-controlled, should be chartered and facilitated through government mailings to consumers to represent the needs of individual consumers in each Health Alliance. The watchdog would collect data, monitor regulatory changes, testify before medical boards, represent consumers in grievances, and provide information to consumers on political and industry attempts to change the system.

III. MANAGED CARE IS ANTI-CONSUMER IN CONCEPTION

A. Consumer Satisfaction

Recent consumer surveys seem to bear out the notion that consumers are less than fully satisfied with HMOs. The data indicate that not only are patients unsatisfied with the care they receive from managed care plans, but that they like independent practitioner settings more than any type of managed care.

A recent Johns Hopkins University study in the *Journal of the American Medical Association* compared HMOs, networks (like IPAs and PPOs), and independent practices in Boston, Chicago and Los Angeles and found patient satisfaction to be universally higher under independent practice settings. A sampling of providers from each practice setting surveyed patients over nine days in 1986. Overall, less than half of all managed care patients rated their care excellent compared to 65% in independent fee-for-service practices. This disparity was exhibited in all facets of care from appointment schedule delays (40% excellent in HMOs to 65% in independent fee-for-service) to telephone access (33% excellent in HMOs to 64% in independent practice).¹⁸ On the whole, consumers are markedly less satisfied with managed care services than independent practices.

¹⁷ NICO Newsletter, vol. xi, nos. 3 and 4, May through August, 1993

¹⁸ Haya R. Rubin MD, PhD et al; Patients Ratings of Outpatient Visits in Different Practice Settings, *Journal of the American Medical Association*, August 18, 1993.

Widespread consumer dissatisfaction is an indication that the quality of care delivered at managed care practices and facilities is below patient expectations about health care delivery. Patient attitudes, however, only demonstrate how the mechanisms of managed care can act to curb the quality of care on an individual basis. The underlying problem, however, is that the manner in which managed care is operated puts perverse incentives on doctors and administrators to wring waste out of consumers and patients rather than out of the system itself. This flaw worries us because it indicates that managed care may not make sense as the sole basis for health reform. Decisions about what resources to allocate where and, how many health services we can afford should be made on a community-wide level. They make no sense if applied only to individuals.

B. Utilization Review

Utilization review is the cornerstone of managed care. It is the oversight mechanism of the plans on the doctors and patients. Utilization review departments within managed care plans monitor, evaluate, and approve the procedures of physicians and other providers based on the condition and needs of the patient. Utilization review processes weed out extra days of hospitalization, unnecessary specialist references, and limit diagnostic tests. In theory, utilization review cuts down on unnecessary procedures and prevents cost escalations coming from overuse of medical services by plan members.

In practice, however, utilization review may limit necessary procedures as much as unnecessary ones without regard to whether the total system can afford those procedures. Certainly, if we are to control costs, we may have to get to the point of limiting care, but that decision should be a last resort, not a first resort mechanism. Utilization review relies on top-heavy administrative costs to offset health care costs, and it is not at all clear that the savings occasioned by such oversight outweighs the financial and quality cost of second-guessing physicians.

Anecdotal evidence and press accounts suggest there are situations where utilization review procedures prevent enrollees from acquiring necessary and vital care. The majority of these disputes between plans and patients arise over billing reimbursement questions. When members seek emergency care outside the geographic limits of the plan or seek specialist services recommended by their primary care doctors but unapproved by the plan utilization reviewers, managed care plans will occasionally cover only a portion of their customary reimbursement.

While failure to pay for needed care may be potentially financially ruinous to a patient who believed the procedure would be covered, it is not life-threatening. Unfortunately, there are also accounts of fatal utilization review decisions. A member of United Healthcare Inc. lost her baby when prenatal hospitalization was denied even though it was recommended by her physician.¹⁹ A member of Lincoln National was required to have a second and third opinion after his doctor recommended he seek care at a specialty heart hospital in St. Louis. Because of the additional delay, he was too weak to survive the operation and died three months later.²⁰

Additionally, although utilization review is supposed to limit unnecessary surgeries and procedures, there is evidence that managed care has higher rates of some surgeries than is optimal. A study by the RAND Corporation found that only 58% of hysterectomies performed in HMOs were appropriate, 25% of them were performed for uncertain reasons, and 16% were inappropriate. The rates of inappropriate surgeries varied among the seven plans studied. From 10% to 27% of the hysterectomies performed were unnecessary. In comparison, RAND cites a 1989 study of the Naval Hospital in San Diego which found only 5% of the hysterectomies were inappropriate.²¹

C. Physician Remuneration

Increasing provider incomes and fees contribute to overall medical expenses and inflation. Managed care plans have sought to constrain those costs by moving away from the traditional fee-for-service payments because they create incentives for physicians to overuse medical services. While there are fee-for-service style managed care plans, they are generally more expensive and have comparable problems with overuse and costs as indemnity fee-for-service plans.

Many managed care plans pay their doctors a monthly capitation fee for each plan member served. Employers pay the plan a fixed amount each month to cover their employees, and the plan pays the providers based on the number of enrollees. This

¹⁹ Wall Street Journal, November 25, 1992

²⁰ Money, April, 1993

²¹ Steven J. Bernstein, MD, MPH, The Appropriateness of Hysterectomy: A Comparison of Care in Seven Health Plans, *Journal of the American Medical Association*, May 12, 1993

dissuades doctors from overusing services to increase their income. However, capitated pay schedules can easily discourage the delivery of care. The doctor is paid a fixed fee regardless of the number of patients who visit the office. These plans have an incentive to provide as little care as possible to the enrollees. Since the plan is paid a set monthly premium from the employer, any care which is not provided is profit for the plan. In practice, the scheduling delays, office waits, and difficulty in contacting the providers by telephone which HMO members reported are ways managed care plans may create an atmosphere which discourages the use of health services. This environment may benefit the HMO, but it hurts the consumer.

Additionally, some plans reward physicians who make fewer referrals to specialists. Either annual bonuses are awarded based on the number of referrals a doctor makes, or a portion of provider income, usually 15-20%, is withheld in an escrow fund and returned only if specialist referral targets are met. The Department of Consumer Affairs in New York City found that 8 of 13 managed care operations in the metropolitan area used some form of withholding or bonus in paying their providers.²² Managed care plans are attempting to keep costly specialist visits to a minimum, but these bonus and withholding policies create an explicit disincentive to give patients access to specialists. It is a clear example of managed care's cost containment strategy being directly opposed to the goal of providing quality care. Doctors may be forced to choose between their livelihood and providing necessary care and access.

CONCLUSION

The corporatization of health care is a direct result of increased reliance on managed care in the health delivery system. This increasing amount of corporate domination of medical decisions is already occurring as we speak but would be sharply accelerated by a move to managed competition.

Profiteering at the expense of health care, high advertising and marketing costs, and industry control of health alliances are all likely results of a managed competition-based health care system. These results are not aberrations, fixable by tinkering with the size or composition of the alliance or premium caps. Rather, they are the inherent predictable result of attempting to restructure our health care system by putting the very corporations most responsible for the skyrocketing costs in our current system in charge of the restructuring.

Still and all, these negative effects might be worth it if we had any indication that managed competition would work, that it would control costs sufficiently to deliver health security to the currently uninsured. But, while it is outside the scope of this testimony to explore why managed care will not control costs, it is clear that it will not.

The only system which we know cuts costs enough to deliver comprehensive health coverage to all Americans is the single payer health care system. Certain validated elements of managed care could be a part of a single payer system, but it would only thrive if people chose to go to HMOs over a traditional independent practitioner. In contrast, managed competition cannot exist without forcing consumers into managed care plans.

Congress should enact a single payer health care system based on the Canadian system like S. 491, the American Health Security Act. In such a system, competition in health care truly benefits the consumer. Competition is between doctors on the basis of efficiency and quality of care rather than between health plans on the basis of price.

²² City of New York Department of Consumer Affairs, *Vital Signs: What the HMOs Don't Tell You That You Need to Know*, April, 1993

Clinton Plan Rewards Big Insurers

To the Editor:

Hillary Rodham Clinton describes the Clinton health plan as "very threatening to those who currently control the insurance market" (front page, Nov. 2). While she may be right to stand up to the smaller insurance companies responsible for misleading television ads, she gives the impression that the Clinton plan takes care of the problem of the private health insurance industry.

Far from threatening the insurers who control the health care system, the managed competition-style plan the Clintons have chosen virtually guarantees that the five largest health insurance companies — Aetna, Prudential, Met Life, Cigna and the Travelers — and a few others will run the show in health care.

A study in September by Marion Merrell Dow found that 21 of the 25 fastest-growing health maintenance organizations were for profit. The big eight (Blue Cross, Cigna, Aetna, Travelers, Met Life, Prudential, Humana and United Health Care) owned 251 of the country's 562 H.M.O.'s, 45 percent, and that's increasing.

While the switch to a managed care system may put hundreds of small to medium-size health insurers out of business, it hands the deal of the century to the huge companies, who got that way by profiteering at consumer expense. The Clinton plan mandates that consumers purchase the insurers' product and subsidizes consumers who can't afford to. That's a reward, not a reform.

Mrs. Clinton made an impassioned plea for "every American to stand up and say to the insurance industry: 'Enough is enough. We want our health care system back.'" She's right, but the way to do it is through a single-payer health care system, which eliminates altogether the role of the private health insurance industry, replacing it with the Government as the sole payer of claims.

The managed competition frame-

work the Clintons have chosen was created by the private health insurance giants of the Alliance for Managed Competition. In bashing smaller insurance companies while rewarding the giants, Mrs. Clinton misleads the public.

SIDNEY WOLFE, M.D.

SARA NICHOLS

Washington, Nov. 2, 1993

The writers are with Public Citizen.

Tops in Bureaucracy

To the Editor:

Discussion of President Clinton's health care proposal has generated alarm about swollen bureaucracies. Consider the following statistics:

In 1990, the number of people employed by the United States Government in all legislative, judicial and



Jennifer Johnson

nondefense executive agencies (including Postal Service and 111,000 temporary Census workers) was 2.173 million.

In 1990, the number of those employed by private insurance carriers and insurance agents was 2.389 million.

ALBERT D. BIDERMAN

Research Professor, School of Public Affairs, American University
Washington, Nov. 1, 1993

The CHAIRMAN. Thank you very much.

We have a full morning, so I will ask that we just take 4 minutes of questions. I think we want to move this process along, so I will ask staff to keep track of the time.

Jamie, we want to thank you for being here. You look like you have recovered very well. Just very briefly, could you tell us how, as a patient, you thought you were treated?

Mr. JAMIE ODELL. I was very, very pleased with the care that I got and with the ease that it was gone through. At first, I would say the HMO really provided a lot of support for me, but the PPO that I was in before did not. I mean, it paid the bills and all that, but I never saw my pediatrician or called him or talked to him the whole time I was in the hospital. There was just no communication. There was very little communication between the hospital and the PPO and my pediatrician.

But then I transferred to the HMO, and there was just a real dramatic difference in the way it was handled.

The CHAIRMAN. So you felt good about that.

Mr. JAMIE ODELL. Yes.

The CHAIRMAN. Mr. McLane, the HIAA says there is less choice under the kind of consumer choice/managed competition plan that both you and the President have proposed. Is this true?

Mr. McLANE. No, sir. We believe that in fact there is greater choice. I believe Senator Dodd put an article into the record which points out 10 reasons why we think there is more choice under a reformed system that is based on managed care and based on managed competition.

I think the bottom line is that there is informed choice, and there is quality choice. You have a choice amongst physicians who are being monitored through outcomes measurement, who are being monitored in terms of how they practice medicine, so that in fact you are insured, I think, of getting better and better quality care.

The CHAIRMAN. As you know, there is lots of controversy about whether health alliances should be mandatory or voluntary, whether there is one alliance to which employers under a certain size must make their contributions, or whether the employer can opt out of the alliance.

What is the position of your members on the question of whether health alliances should be compulsory or voluntary?

Mr. McLANE. You get right to the crux of the matter very quickly, Mr. Chairman. [Laughter.]

The CHAIRMAN. Yes. That is what Senator Dodd said we should do.

Senator WELLSTONE. It is what comes with the 4-minute rule.

Mr. McLANE. I think basically, an employer mandate is not going to guarantee universal coverage. I think we find that in Hawaii, for example, where they have had an employer mandate, and they have had to work that law in order to cover the low income that an employer mandate, or any other type of mandate they have tried to put in, to work.

So I think one thing we have to keep in mind is that an employer mandate does not cover everybody that you might expect; second, that an employer mandate, the question of jobs and all that, I am not an expert on, and I would just ask that that be looked into.

That clearly has been raised by many people in terms of what that does to small business. From all I have read and seen, I think it has a significant negative impact on small business.

In terms of individual mandate, they tend to go hand-in-hand, and I think on the individual mandate that if you are in the smaller companies and the individual is mandated, you are going to have to get at how that is going to be paid for in terms of subsidies, which the President's plan does deal with.

To me, those are the trade-offs. It is the jobs on the employer mandate and the subsidies on the individual mandate.

The CHAIRMAN. My time is up, but finally, if the managed care programs are going to be effective and work and get a handle on costs, then obviously the mechanism in terms of the overall budgeting will not be triggered. I mean, that is the concept behind the budget. So if we follow your recommendations and suggestions, and the competition is going to work and is able to depress costs, why would you be so concerned about the existence of some kind of a cost containment program as a backstop—as long as it was realistic? We may have some differences about whether it is realistic or not, but as a concept, why would you be so concerned about it?

Mr. McLANE. I think as a concept, as something in the closet, down the road, if you are not able to make the competitive system work, it is one way of viewing it. Again from my experience, any time you get close to any type of price controls, you get capital flight, you lock in inefficiencies, you get people focused on gaming the system rather than the structural reform we need. I think it is a short-term political solution and not a long-term structural reform solution, and clearly we need long-term structural reform.

So that, as was pointed out by Sara Nichols, I think the assumption was that lots and lots of people are in managed care. About 16 percent of the population today is in HMOs, and an awful lot of those have come in in the last 5 years. So this is still relatively new, this strong form managed care.

You saw in the last year that medical inflation—and we are now beginning to grab hold of it—is up something like 5.6 percent as opposed to 9.5, 9.6 percent the previous year and higher in previous years. It is beginning to work in these markets. You have seen the statistics, you have seen what various companies are doing, you have seen what various managed health care plans are doing.

I am very encouraged by what is beginning to happen in market after market, but it differs all over the lot. Some markets are much further along in managed care, and where they are, their price increases are substantially less than those that have yet to embrace it.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

I will try to be quick before the time runs out. I would like to ask anybody, perhaps Ms. Franklin. I am a big supporter of integrated systems of care, and I think all of you have spoken very persuasively, even Ms. Nichols, to the importance of that concept. What I would like to ask about is the issue of risk-selection and how it can be dealt with in a system of voluntary alliances. As some of you know, I have grave reservations about the administra-

tion's health alliance structure as being too large and the mandatory purchasing arrangement. However, one of the criticisms of the voluntary competing cooperatives is that they would not fully address risk selection still in the market, and thus that you would still have the problem that has caused concerns in the present system. Do you think that would occur? If not, how would you address it?

Ms. FRANKLIN. Senator, I do not know if I am the best one to answer that question, being that I am from a very clinical background. I can speak from my experience in that regard, but perhaps Mr. McLane could address that.

Mr. McLANE. California is the first State that really has HIPC's up and running. They have been up and running since the 1st of July. They are voluntary. I think we are up to 16,000 or 20,000 members. There appears to be a fairly broad selection of risk at this point, but again, you are dealing with 16,000 or 20,000 out of 20 million or whatever California is. But progress is being made.

The real concern about voluntary and why The Alliance for Managed Competition generally believes in exclusive alliances is that opportunity to be selected against or to still select as a voluntary HIPC, whereas an exclusive HIPC, with its rules and regulations that are set up, essentially eliminates all the insurance underwriting practices that we clearly have to eliminate.

Senator KASSEBAUM. So you would be supportive of moving toward community-based rating.

Mr. McLANE. Yes, we are, and have advocated that position.

Senator KASSEBAUM. One other concern that has been raised about managed care generally is that while you can prove that in some cases it has been effective in reducing costs, CBO has shown that actually, managed care may not actually be a long-term answer to the problem. Specifically, CBO has found that there is only limited value in achieving long-term control of cost. They estimate that there is a short-term \$10 or \$15 billion in savings, but that would be only a one-time savings. How do you answer that?

Mr. McLANE. Well, I can only answer from my experience, which is that in the markets where managed competition is beginning to take hold, those are long-term savings, and they are substantial. I have cited in my testimony the percentages of the types of savings.

I have also in my written testimony and with the attachments—we made a bunch of assumptions—anybody can make any assumptions they want—and we think that the managed competition system when fully employed over a 5-year period can save this economy—off those assumptions, it was \$290 billion. So you are looking at a very sizable, sustainable savings over an extended period of time through managed competition.

Senator KASSEBAUM. I have only a few seconds remaining, but how do you respond to criticisms that savings from managed systems come from the fact they tend to serve healthier populations? Do you think as up to this point, largely, that your enrollees have tended to be healthier.

Mr. McLANE. That is correct. That is correct, although in some markets now, where your strong form managed care is now 50, 60, 70 percent of the population, it is no longer skewed; there just are

not that many young, healthy people in a local market. So that has broadened out, and the evidence still holds.

Senator KASSEBAUM. Thank you very much.

Mr. McLANE. I think you just saw an example of it here with Harvard Community Health Plan. I am sure those costs were enormous. Mr. Odell does not even know what they were, and does not need to know what they were. He pays his copay, but the Harvard Community Health Plan balances that out over the rest of their population because I believe there are something like 600,000 members in that plan.

Senator KASSEBAUM. And would there be any consideration of prior health condition going into managed care?

Mr. McLANE. No.

Senator KASSEBAUM. That is not a consideration—never?

Mr. McLANE. No. Elimination of pre-existing conditions is something that any reform should have.

Senator KASSEBAUM. Right, but does it exist now in any of the plans?

Mr. McLANE. Oh, I believe it exists in a number of the HMOs and whatnot.

Senator KASSEBAUM. It probably would, yes.

Thank you very much.

The CHAIRMAN. Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman.

As you pointed out with Senator Kennedy, I think it is important to note that there is some debate, even within The Alliance for Managed Competition. You have a somewhat different view than some of your colleagues.

Mr. McLANE. That is correct.

Senator DODD. I think that it is important to note that you are more inclined to go with exclusivity, and your colleagues in that group are not inclined to, and that is a legitimate point.

Mr. McLANE. I think most are, but as I said, Senator, those really are issues that deal with somebody coming to grips with this job issue and then coming to grips with the payment issue.

Senator DODD. Yes. I, but think it is fair to point out that there is some debate. So, I would say to my colleagues that within the Alliance, on that particular point, there is not a monolithic view at all.

Mr. McLANE. Senator, that is managed competition. It is not monolithic at all.

Senator DODD. I understand.

Sara, thank you for your testimony. Although we are talking about relatively small numbers here, I am struck with the example of the Mayo Clinic as an example. I do not know if you are familiar with what they have been able to do in terms of promoting efficiencies within the system. Granted, it is one place, and you have to be careful about trying to extrapolate, but it may be instructive to get some comments from you on it.

It has had some 2,700 administrators for 800 physicians. I am just quoting these numbers, and I presume they are accurate. And they have succeeded in reigning in their cost per patient in terms of revenue increases to 4.8 percent, which is about half the national average, as a result of the managed care system they put in place.

One example of their cost containment success occurred when orthopedic surgeons, after agreeing on acceptable brands, started competitive bidding to bring down to \$850 what was marketed by certain manufacturers as a \$2,600 hip replacement.

How do you respond to this type of example, the California example, where costs have been brought down tremendously? Granted, it is 16,000 people, not 20 million. But there seem to be in these examples real results, not just theoretical debates and discussions. There appear to be some real cost savings and real efficiencies emerging as a result of this process.

How do you address the issue of greater efficiency and cost containment when you are talking about a single-payer? There are some examples, but it seems not to the extent that exists in the examples I have raised.

Ms. NICHOLS. Well, Senator, thank you. That is a very good question. I think that the examples of managed care facilities which have succeeded in lowering costs in those instances are definitively success stories. But they are not systems; they are not health systems which you can then import to the entire Nation or to an entire State. They are just a managed care facility. And there are ways in which various unique managed care facilities are able to bring down costs because of their particular ability, with the particular population that they have, whether it be healthier or whether it be better able to sustain costs within that.

In contrast, the single-payer has the success over entire nations—Canada, of course, being the example we most often point to, where costs are rising at 9 percent a year versus 14 percent in this country. It is very clear that by switching to a single-payer system, you can save close to \$100 billion a year, and that is something we know for a fact.

What we do not know for a fact is whether examples like the Mayo Clinic are translatable to a national scale and whether, once you build in the bureaucracies of health alliances and all the other trappings of managed competition, that kind of savings would still be there.

Senator DODD. Just for the sake of discussion, though, Canada and our country are very different. I mean, there is a far greater degree of homogeneity, I would suggest, in Canada than there is here.

Jamie, would you respond to that same question?

Mr. McLANE. Yes, sir. There are a couple of things. You cited the Mayo. One of the things that is also interesting about the Mayo is not only the costs, but what they are doing in terms of reaching out to rural America.

The big problem in rural America is primary care physicians—it is physicians of any type, but principally primary care physicians—because you cannot get enough into these communities, and when they are there, they cannot leave, because there are either one or two of them there, and they cannot leave.

Mayo is now reaching out into the communities. They are taking somebody from the Mayo Clinic who will actually go into that community so that person can leave. What they are doing is actually providing training for some of those primary care physicians; they will come in to Mayo for 2 or 3 weeks to be updated and then go

back to their communities. They will put one of their own physicians in so that doctor can go on vacation for 2 weeks. So there are a lot of things that Mayo is doing on that.

Again, health care is local, and it is not national. It is very local, and it is very different in the area that Mayo is serving than in Los Angeles or in Kansas City or in New Hampshire or in Dallas or wherever. And the managed care that is shaping around these particular communities is a bit different, in order to get costs down, quality of health care up, customer service, all those things. So they are taking different shapes. So the Mayo Clinic might not work in Hartford, but something else will work in that area and achieve essentially the same results.

Another point you made that I think is very, very valid—in all these comparisons that everybody makes to Canada is not only the homogeneity, but Canada does not have the assault rate, does not have the murder rate, does not have the drug and alcohol abuse rates that we have. Any of you who have been in an emergency room, like I have in the last 2 years, that is what the emergency rooms are filled with. That is high-cost medicine, and that is a whole different social, pathological thing that we are going to have to come to grips with, I hope, as you are debating the crime bill and other things that have to be dealt with.

Senator DODD. Just last night, a group of us met here for about 4 or 5 hours to discuss youth violence, and we had some police officers from New York, and that was something we talked about, getting the public to be aware. One nonfatal gunshot wound in New York is worth \$30,000. And if you have to stay in the hospital for 4 or 5 weeks, it goes up to around \$150,000 for that single bullet. We had some doctors from CDC, and I know the chairman has met with them in the past. So if people had some idea what those things cost.

My time has expired, but I cannot resist asking you this question because it has bothered me tremendously over the last several weeks, this lumping together. And I make no bones about it—I am a cosponsor of the Clinton health care plan. I think it is the best alternative out there. And I am very proud of the fact that a good part of the insurance industry is located in my State. I do not apologize to anyone for that. They have been great corporate citizens and have done a great job in many areas, in my view.

But there is a tendency to lump all of the industry together, and there have been ads on television that have caused a lot of concern among many people. I have expressed my views on the floor of the Senate about it. I cannot resist asking you—you are not a member of HIAA, and I would like to know what your reaction is to those ads.

Mr. McLANE. Well, Senator, clearly, there are different spectrums on this debate. The physicians have different approaches depending on what specialty they are in; the insurance companies have different approaches. We are a managed health care company, and I think as a managed health care company, we are trying to focus on a solution that builds on the experiences that we have found in managed health care.

Point two is that I think in listening to people like Kathleen and others in these companies, whose whole lives have been involved

with health care, we want to be part of the solution. We want to try to work with you in terms of what our practical experience is from what you are proposing. And that is all we are going to be able to do. You all have the wisdom to pass the law that makes sense. All we want to be able to do is to come back and say, well, look, let us just explain to you how this works or does not work operationally.

So that is our stance.

Senator DODD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Gregg.

Senator GREGG. Thank you.

Just a couple of thoughts. Was this the Tyngsboro Bridge you were jumping off, Jamie? [Laughter.]

As I understand it, Mr. Odell, you feel that if you had not been able to go to Mass General, and you had not been able to go to Children's, that Jamie's possibility for recovery and adequate care would have been significantly different because of the quality of care you received at those two exceptional facilities?

Mr. ODELL. Partly, yes. We cannot say, because we went straight there. We had no chance to test inferior ones.

Mr. JAMIE ODELL. The longer you wait, the worse it gets.

Mr. ODELL. Yes, the longer you wait, the worse it gets. So it is very important to get started on the plasmaphereses.

Senator GREGG. And of course, it is nice to have the ability to go to Children's and Mass General, which are the premier hospitals in the world.

Mr. ODELL. Exactly. What we found was that as thing went on, the particular clinic we were part of, which is a PPO type, was not facilitating nearly as much as the downtown headquarters operation was facilitating things. That is when we began to understand the differences within a system like that.

Senator GREGG. Then also, I take it, there was this unique treatment that had been developed in Holland that was critical to the process, and that I guess Children's immediately used.

Mr. ODELL. Right. And there was never a question as to being able to get access to that.

There were three things that we noticed. First, we followed our doctor into this organization. Our pediatrician out in our rural area said, "I am closing down my practice, and I am moving into this plan." At that time, we were really worried about our costs, and when we looked at it then, our costs went down. It was a cheaper option for us—and it still is, according to the other plans that we see out there in our area.

The Harvard name implies a certain elitism—and this is getting into the different debate here about the variety of experiences that are out there in terms of HMOs and so forth. If I am not mistaken, I think the Harvard plan started in the inner city. It started as an experiment in the center of Boston.

Senator GREGG. I think it started in Cambridge.

Mr. ODELL. Yes, and the Kenmore Center and so forth. I know people who work in the centers, and they have a very high proportion of not healthy and wealthy population. It went out to the suburbs later.

Senator GREGG. My point in raising this is that—unfortunately, I only have 4 minutes—my point here is that under the Clinton plan, both of those things which are critical to Jamie's recovery would be at risk, because under the Clinton plan, if you did not live in Lowell, but you lived in Nashua, just a few yards from the Tyngsboro Bridge, you probably could not have gotten to Children's or to Mass General for care. And under the Clinton plan, the national health board would have to have approved the treatment which was brought in from Holland before it could have been delivered to Jamie. So you would have had to go through this huge bureaucracy before that treatment could have occurred.

So I think the treatment that you have gotten under the Harvard plan makes a lot of sense, and the reason it makes a lot of sense is because it is in the marketplace, and it is competing in the marketplace, and it is not yet dominated by the central decisionmaking policy which is proposed by the Clinton plan.

If I could move to Mr. McLane and ask you a question, Mr. McLane. If you were to analyze the Clinton plan as it relates to managed competition—it has been held out as managed competition but it differs from managed competition clearly as proposed by the Jackson Hole Group—are you familiar enough with traditional managed competition to say this is where the Clinton plan differs and would not work, and this is where it does not differ and would work? If you could, could you give us that analysis?

Mr. McLANE. Yes, sir. I have actually waded through this, but I can also say I do not fully understand all the implications and linkages. This is a very complicated piece of legislation, and we are still working on it. But at this particular point in time, there are a couple things.

One is the regulatory nature of these alliances. It looks to me as if it is not really managed competition, but that there is a very heavy Government interference with them, which gets to your point, I think, a little bit there. You said that if he had not lived in Massachusetts, he might not have gotten to Mass General. That is not true. In a managed care environment, we have Institutes of Excellence all over the country.

Senator GREGG. I am talking about under the Clinton plan.

Mr. McLANE. Yes, but I am just saying that under a managed care environment, we would send Mr. Odell to one of our Institutes of Excellence. In this case, it might have been Mass General; I cited the case of the child in the South who went to Minnesota.

So I am concerned about the regulatory nature of these alliances which does not allow managed competition to operate, or at least I do not think they do. Again, I have not fully analyzed this, but I am concerned about that, because that will in fact step in the way of a lot of these types of behavior patterns, when the Government says this is what you are going to do or not do. That is the biggest concern.

The problem of the uninsured, underinsured, tends to be at 100 employees or less. We have got to get portability, and you can cover the exceptions outside of that. But I would hope that the final solution that this committee and the Congress comes to grips with is let us fix the problem and focus on that problem, and let us get

that fixed rather than totally changing a system which has many, many strengths, which you have just heard about.

Senator GREGG. One of the problems being cost. We only have CBO numbers from 1990, I think is the latest year we have got them for. What are your most recent experiences in rate of growth of costs?

Mr. McLANE. In terms of price increases?

Senator GREGG. Yes.

Mr. McLANE. In managed care, they are running nationally at around 5, 6 percent; 4 in some markets, 3 in others. And even more importantly, there are some major companies that have their own plans that drive very hard. The Harvard Community Health Plans, the Aetna Health Plans, the CIGNA Health Plans, and they are keeping them at one and 2 percent. They are applying a lot of imagination and creativity and the pressure of large numbers, which is like an alliance.

Senator GREGG. Do you expect that to continue, or do you expect it to go up?

Mr. McLANE. No. I think managed competition is just beginning to come into its own, and that is why I would expect it to continue.

Senator GREGG. Thank you.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you.

I sprinted back here, Mr. McLane, from the Committee on Energy and Natural Resources, to put a couple of questions to you and other members of the panel. I just want to cite some figure that Ms. Nichols had listed in her testimony. I do not know that she had time to go into all the specifics, and I only have 4 minutes, but she cites a recent study by Marion Merrell Dow that found that 21 of the 25 fastest-growing HMOs were for profit and that the "Big 8"—Blue Cross, CIGNA, Aetna, Travelers, MetLife, Prudential, Humana, and United Health Care—own 251 of the 562, or 45 percent of the HMOs in the country. This may come to the question of managed competition and who manages the managed competition. The trend here is not one of what we would call a highly competitive small business free enterprise economy, with lots of competition. The trend here is toward enormous concentration of economic power not in the allocation of toothpaste, or TV sets, or haircuts, but the allocation of health care.

Mr. McLANE. Right.

Senator WELLSTONE. Does this give you any cause for concern?

Mr. McLANE. No, Senator, because I think those facts are gross, national. Let me give you some facts that I have actually gone through. Take Connecticut, for example. The largest health plans in Connecticut are ConnectiCare, Oxford, and one other—it is not CIGNA, it is not Aetna Health Plans. Take Massachusetts—Harvard Community Health Plan, the Tufts New England Medical Center, Pilgrim. Take New Hampshire—it is Health Source, Matthew Thornton. Take Kansas, or the Kansas side of Kansas City—it is Blue Cross/Blue Shield, Humana Prime Health, Kaiser Permanente, Principle.

I know this is a concern because I read the papers, too, and I actually went through the 20 largest markets that we are in. The

local and regional managed care companies run two or more of the top five managed care companies in 15 of those 20 markets.

I am not competing against the other members of The Alliance for Managed Competition. I am competing against local and regional HMOs like the Harvard Community Health Plan, like some of these names I brought up, like U.S. Health Care, like Pacific Care, like Take Care. They are not members of The Alliance for Managed Competition. They are not one of the "Big Five." That is managed competition. That is what it is all about.

Senator WELLSTONE. Well, you can draw from the example of Connecticut or a particular State, but after all, we are talking about what we are going to do at the national level by way of national reform.

Mr. McLANE. Yes, sir. I can do that in any State; we could go through that, and I would be more than happy to submit to you the top five players State by State, if that would be helpful.

Senator WELLSTONE. Well, I am not a statistician. So your point is these figures do not indicate any trend of the large—not midsize or small—insurance companies, but larger insurance companies or for profits coming in—I have 1 minute remaining—and essentially controlling this market?

Mr. McLANE. Senator, large insurance companies do not control those markets. As I said, we are competing head-to-head with some of those names that I was talking to you about. We compete head-to-head, and I can tell you case after case situation that you lose those players.

Senator WELLSTONE. Let me ask Ms. Nichols to comment because I think these are figures in the country as to where the trend is, and let me tell you the reason I ask the question, and maybe when we get into the next panel, Mr. Chairman, we can get into these questions in more detail.

In Minnesota, we had a rather amazing development, which was not more than about a month ago, the American Medical Association, the Minnesota Medical Association, in a very close vote—something like 86-82—called for the State to study single-payer as an option. Now, the reason for that was not that the caregivers were dissatisfied with every, single managed care plan or HMO—not at all. Some are very good. But what they are very demoralized about and very dissatisfied with, and I think kind of indignant about, is some of the third party payment, 1-800, micro-managed plans where the bottom line has become the only line and severely damaged doctor-patient relationship.

I hear a lot from caregivers about that, and I think it has to do with these very folks moving into this field. Could you respond to this difference of perspective that two of you have? And then I am done. My 1 minute is gone, but you still have time.

Ms. NICHOLS. Thank you, Senator.

The fact is that while there are obviously still lots of smaller HMOs in State around the country, the trend is in the direction of the larger companies owning and operating more and more HMOs.

In fact there was a study done earlier, in April, that we cite in here, 1993, showing CIGNA owning 42 plans, Prudential 28, MetLife 14, Travelers 9, Humana 17. Well, only 3 months later, every, single one of those companies owned more plans. Humana

jumped from 14 to 25 plans that they owned in just that short amount of time, and the insurance companies in there also jumped.

The fact is that the trend is toward insurance ownership and large corporation ownership of HMOs, and when you think realistically about which companies are going to be able to move in when there is a sudden opening for lots of HMOs under managed competition, obviously the companies with the most capital and the most mobility and the most plans are going to be uniquely poised to profit from that system.

Senator WELLSTONE. Thank you, Ms. Nichols.

Mr. McLane, could I get the list from you? You said that you could provide that. That would be very helpful.

Mr. McLANE. Yes, I will provide that.

Senator WELLSTONE. I appreciate it. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I would like a copy of the list, too, because I think I know where you are coming from, and I would just add, if I may, a Minnesota dimension to it. The four big plans in Minnesota are all big, but they are all local. They are all local. There is not a Kaiser in Minnesota. You could not get into the Minnesota market with your Aetna plan because the local companies are doing such a good job for local people. Now, they may be scaring some doctors, they may be worrying some doctors, who like it the way it has been in the past—but they are all local companies—Preferred One, a big PPO; the original Group Health, which tried to get beat out by the AMA way back in the 1930's, is still there. They have grown to over 600,000 members because they are managing it the way people need to have it managed. Blue Cross/Blue Shield in Minnesota is very different from Blue Cross/Blue Shield in North Dakota, which is in effect owned by the doctors and the hospitals. And it is doing well by them. Medica is the HMO subsidiary of United Health Care. It is a local product.

On Sunday, Mr. Chairman, I had lunch down in Atlanta with Bill Roper, and Bill is trying to set up something for Prudential that will estimate how to get better outcomes, a market at a time. And while Pru Care has a little bit of business in Minnesota, they are not sure how long they are going to be in Minnesota. This really is the interesting thing about the change that is taking place. We currently have 600,000 doctors competing with each other theoretically, but they are not really competing because none of their patients have any information about what goes on. We presume that the Mayo Clinic is one of the best in the country, but we really do not know. I like to think so. That is one of the reasons why they can manage better and keep their costs down. But we really do not know. We really do not know because we do not have enough information to make these comparisons.

One of the important things you seem to get out of these hearings is trying to distinguish between managed competition and managed care. What the young man was talking about before I came in was a process that manages the whole of him and all of his experience, not just one little part of him.

I think we all read the story on Sunday about the cardiovascular surgeon who said, "I love sleeves. I kind of like to work on sleeves rather than the sweater." Some people kind of like that. But what we all need is a system that works for the totality of us and our families. And I think whether you call it an HMO or whatever—and it will vary from market to market—the concept of managed care is that, and the goal and the objective, I presume, is that.

Managed competition—and we see so little of it—largely is people who want to manage your care better, competing with each other to have you come and enjoy the service that they might have, under a set of rules.

I think President Clinton has suggested that we establish national rules for accountable health plans, or health alliances, or whatever, and then we use local markets, using these national rules. Basically, if we want to look for definitions and get consistency in our language, that is probably the best place for us to go.

I have a concern, and maybe Mr. McLane or someone else can respond to it. This is choice time under the Federal Employee Health Benefit Plan, and we are all going to have to start making choices. I might say to the lawyer from the Nader group, that one of the original health alliances was the Federal Employee Health Benefit Plan, and we are still given a variety of choices, but the concept of a health alliance is not a new thing, and it is not an evil thing, and it is not necessarily a bureaucracy. But for some reason or another, the Clinton health plan proposes to eliminate this relationship between us, as employer, and all of these people and to replace it with sort of a District of Columbia health alliance and a Northern Virginia health alliance and a Minneapolis-St. Paul health alliance, or whatever the case may be.

I cannot quite understand why ghettoizing health care delivery here in this area is a good idea for Federal employees. We have some national institutions, like George Washington and Georgetown Universities and places like that, in this city, and their business comes from all over. Maybe you can help me understand this—why should we abandon an employer alliance for sort of a geographic alliance to ensure that we are getting accountable health plans and appropriate provision of services?

Mr. McLANE. Well, Senator—and please, other people, speak up on this—one, as I pointed out, I do not think we should be adopting alliances at the size that the President has proposed of 5,000 employees or less because of the main reasons that you were pointing out there.

Clearly, the problem tends to be in the 100 employees or less. Those tend to be more locally based, so therefore an alliance will tend to solve their problems more effectively.

The other point that you were pointing out—what managed care companies are measured on and have to be measured on, be it the Harvard Community Health Plan, or Aetna Health Plans or whatever, and will be measured on, is cost of care, the quality of care, in terms of the measurements that will be coming forward here, as well as the service that is provided to Jamie and others as part of that. That is all part of your physician-patient relationship, and that is how we are going to be measured in terms of the way we progress.

Ms. NICHOLS. If I might just add to that, I think, Senator Durenberger, you raise a very excellent point. There is a lot of concern that there might be multiple health alliances within a region like this, and that could cause a lot of problems. But it just highlights the kinds of problems that you can have when you are constructing a health alliance in general.

Even to look at the Federal health benefits plan—which I think most people would agree is the best example we have of a better-functioning way of choosing plans—even that has had a fair amount of problems. The difficulty of providing understandable information about the various plans before the Federal plan has caused the Office of Personnel Management never to do any independent analysis or compilation of the information. They take what the health plans give them, and they put them right out. That is referenced in my testimony, and it is an important thing to look at as an example of the difficulty of constructing an alliance which really can have enough control over health plans to protect the consumer.

Senator DURENBERGER. Mr. Odell.

Mr. ODELL. Yes, to respond, Senator, I think choice is a critical part of this whole thing. I am not saying that everybody in Massachusetts or in New England should join this plan at all. I think they should have the choice, and this should be one of the options open to them.

We did that; we shopped. At the beginning, we did not anticipate anything like this. We were looking strictly for good service and low cost. And when we added it up, we paid less per year in terms of our overall exposure for normal things, and we got much more comprehensive care.

But in terms of Jamie's major disaster that struck him out of the blue, we were not in the Boston area. We were out in the boonies. We were at a little hospital out at the New Hampshire border—but they did not even let Jamie in the door of that hospital. His neurologist saw that he had a problem that could not be dealt with, and he put him in an ambulance, and he sent him past about six other hospitals on the way to the one where he knew he could get care. So there was never a problem about getting that handled.

So he did not have to go to Boston. He could have easily gone to Minneapolis or Houston—any major medical center would have this plasmaphereses. But the Amesbury Hospital and so forth in our little area would not have it. But they were able to recognize it and, as Jamie said, time is of the essence. A system that works like a business—I think efficiency is very important, and this seemed to work like a business.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. No questions, Mr. Chairman.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. No questions.

The CHAIRMAN. Just very briefly—and I would say this if Senator Gregg were here—not all the representations of the President's plan are, I think, what the President or Mrs. Clinton would accept in terms of definition. We want our witnesses to be able to respond

to those questions which are the real questions that need to be answered. But in the President's plan, States can require health plans to guarantee their members access to centers of excellence. That is clearly the intent of the program, and that is what those of us who are supportive of the program would wish.

We want to move along, but I would like to submit some additional questions, Mr. McLane, on the 100 cut-off number you mentioned versus the bargaining power of larger groups and alliances, as well as other matters. And if other members have additional questions, they will submit those to you.

We want to thank all of you very much for being here this morning.

Mr. McLANE. Thank you.

The CHAIRMAN. Leading off the second panel is Lisa McGiffert from Consumers Union. Consumers Union publishes Consumer Reports—that is probably what they are most famous for, but they have also given Congress a good deal of advice over the years on a number of consumer issues. Health reform is probably one of the biggest consumer issues, so we look forward to hearing Ms. McGiffert's testimony this morning.

Chip Kahn is well-known to members of the committee. He used to be chief health aide to Senator Quayle and moved to Senator Durenberger's staff and then over to the House of Representatives to become staff director for the minority on the Ways and Means committee. Now he is executive vice president of the Health Insurance Association of America.

We welcome you both, and we will start off with Ms. McGiffert.

STATEMENTS OF LISA MCGIFFERT, POLICY ANALYST, CONSUMERS UNION, AUSTIN, TX; AND CHARLES N. KAHN, EXECUTIVE VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Ms. MCGIFFERT. Hello. Thank you, Senator.

Consumers Union appreciates the opportunity to comment on the role of the health insurance industry in the Clinton administration's proposed Health Security Act. As Senator Kennedy has said, we are the publishers of Consumer Reports Magazine, and I work in an advocacy office in Austin, TX and work on regional issues with regard to health care reform.

Consumers Union fully encourages and supports a private marketplace. We rate such products as cars, toothpaste, and alarm clocks in an effort to help consumers get the most for their money.

But dealing with insurance, the ticket to health care, is a different story. Health care is more than a right. It is a basic human necessity. As a Nation, we have reached consensus that we need to ensure that every American has access to health care.

Even Harry and Louise, the stars of the HIAA ads that we have all become so familiar with, seem to be looking for a better way. But consumers do not need the health insurance industry telling them what to think. If they had a better way, we would not be in the fix we are in today. Their better way is maintaining the status quo. And Consumers Union is dubious that private health insurance will ever meet the needs of our Nation's consumers. Every

day, Americans are facing devastating depletion of their life savings, simply because they are inadequately covered by insurance.

Consumers Union has advocated for health insurance reforms for many years on a national level and a State level. Especially on the State level, we have witnessed the consequences of insurance industry controlled regulation. Because of this work and the very nature of health insurance, we are not optimistic that reforming the market alone can create a truly competitive and universal system.

For this reason, Consumers Union prefers a single-payer system because we believe it could best meet the health care needs of American consumers.

First of all, I would like to very quickly review some of the major problems for consumers in the health insurance marketplace. First of all, it is a very costly system with administrative inefficiency that is built into it. It accounts for in excess of \$70 billion per year that it spent not only on insurance industry overhead, but overhead on the part of providers in order to build the multitude of companies that are the payers.

It unfairly cuts people out. Excluding coverage for pre-existing conditions is the most common practice used by insurers to limit their financial risk. Millions of Americans are unable to find health insurance coverage they can afford to cover the care most critical to them. Today, pre-existing condition exclusions cover a broad range, from the very serious to the quite common and minor conditions.

To minimize their exposure to risk and to maximize profits for their shareholders, insurers rely on medical underwriting and what we call "cherry-picking" the good risks. The industry has taken the practice of underwriting to an extreme and carved out or priced out virtually every group who is perceived to be a high risk.

These practices create an especially stiff burden for small businesses, the self-employed, and individuals who are trying to get insurance. And as we know, the larger companies have opted out of the system altogether.

The insurance industry is not accountable to consumers. Regulation at the State level, in our opinion, has failed. Insurers have been quite successful in their efforts to exert influence over State regulation in legislatures and in various insurance departments. Their lobbying efforts are aggressive, and they use our consumer dollars quite effectively in getting what they want from these regulatory bodies.

I saw last night that HIAA alone is spending \$6.5 million to attempt to sway the American public against significant reforms. In some States—and as we have State by State regulation, it is very much patchwork—in some States like Texas, there is virtually no regulation on health insurance, and it leaves consumers quite unprotected from marketplace abuses.

The Clinton proposal does have a number of positive features for reining in insurance company practices that I would like to point out.

The President's bill clearly recognizes the most serious problems consumers face and attempts to address them. The best way, in our opinion, to eliminate these problems is to remove the private insurance industry entirely from health care. However, if Congress is

not willing to take such action, elaborate steps will be needed to restrain companies from practices that discriminate unfairly against the very people who need the care the most.

Insurance reform measures will retain and add complexities in our already complicated system, but they are absolutely necessary if private insurance companies are to remain the major payers in our system.

The insurance reforms recommended in the President's bill are similar to many proposals that Consumers Union has long endorsed. First of all, insurance companies will no longer be able to use underwriting practices unfairly or pre-existing condition exclusions. The health plans will be required to accept every eligible person who is enrolled by the alliance, regardless of their individual characteristics, health status, anticipated need for care, occupation, or affiliation. There will be no waiting periods or riders that exclude certain illnesses or conditions. Furthermore, health plans cannot terminate the coverage for any reason.

The Clinton plan's standard comprehensive benefit package will cover people's health care needs and provide the fundamental building block for a health care system that is intended to be accountable to consumers. Competition cannot work if consumers are ill-informed, misinformed, or confused. Standardization allows informed consumers to make clear comparisons among available plans and make choices based on quality and cost. Uniformity among packages can make it easier for consumers to identify when a particular health plan is not fulfilling its responsibilities. Additionally, the administrative simplicity of a standard package could save us some in cost.

The alliance-prepared report cards in the President's plan will provide consumers with objective information about each plan. While some organizations like Consumers Union have attempted to provide this kind of information to consumers to sort through the fine print and the complexities, there is no truly universal system that consumers can turn to, and the Clinton plan puts that responsibility squarely in the hands of each regional alliance.

Community rating in the Clinton plan will make premium costs more reasonable. This is a rating system whereby insurers offer insurance at fixed rates to all purchasers, and we feel that it is an important and appropriate remedy to risk aversion practices that are common among insurers today.

The concept of community rating which was originally used by Blue Cross/Blue Shield worked well until for-profit insurance companies began creaming off the young, healthy groups by offering them lower rates based on each group's actual health experience. We know this practice as experience rating. It leaves those in greatest need of health care either totally shut out of coverage or facing prohibitively high costs.

The CHAIRMAN. I will give you another minute or so to wrap up.

Ms. MCGIFFERT. The Clinton proposal sets up a risk adjustment mechanism through which all plans within an alliance will be required to spread the costs of high-risk persons. The Clinton plan also subjects the insurance industry to FTC scrutiny, which will give us some Federal oversight, and repeals the McCarran-Fer-

guson Act, which makes insurance companies immune from anti-trust laws.

Quickly, we have some recommendations for improvement to the Clinton plan. Basically, we think it needs to make it easier for consumers to have complaints resolved. We think that each alliance should set standards for health plan performance, such as limiting administrative costs to the same level as Medicare. There should be strong protections against redlining at the health plan level, and the supplemental market needs to be more tightly regulated because we will anticipate a great deal of supplemental market activity going on.

We also think the Clinton plan should make freedom of choice of health care provider a real option for consumers at all income levels, and we have some ideas on how that can be accomplished.

While we would prefer a system that does not rely on the insurance industry, we believe the Clinton plan addresses some of the insurers' most glaring health care market abuses, and we hope that congress, as it considers these reform proposals, will choose to strenuously regulate the health insurance industry.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. McGiffert follows:]

PREPARED STATEMENT OF LISA MCGIFFERT

INTRODUCTION

Consumers Union¹ appreciates the opportunity to comment on the role of the health insurance industry in the Clinton Administration's proposed Health Security Act. Consumers Union fully encourages and supports a private marketplace for consumer products such as cars, but not for health insurance. As a nation, we have reached consensus that we need to ensure that every American has access to health care. While many continue to want to fit the square peg of insurance into the round hole of universality, Consumers Union remains dubious that private health insurance will ever meet the needs of our nation's consumers. Every day Americans are facing devastating depletion of their life savings, because they are not covered adequately by insurance. We are encouraged that America's leaders have now recognized the absolute necessity of changing this situation.

Consumers Union has advocated for health insurance reforms for many years on the national level and in several states, where we have witnessed the consequences of insurance industry-controlled regulation. Because of this work and the very nature of health insurance, we are not optimistic that reforming the market alone can create a truly competitive and universal system. For this reason Consumers Union prefers a single-payer system, because we believe it could best meet the health care needs of American consumers. The strengths of this model, which approaches the health care crisis in a global and comprehensive manner, are its relative simplicity, its ability to control health costs, its fair financing, accountability to consumers, and the way it preserves consumers' freedom to choose where they will go for health care and who will provide it. These are basic principles that Consumers Union uses to guide our analyses of the various reform proposals being considered.

¹ Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the state of New York to provide consumers with information, education, and counsel about consumer goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is derived from the sale of Consumer Reports, its other publications and from nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulator actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

I. PROBLEMS FOR CONSUMERS IN HEALTH INSURANCE MARKETPLACE

Administrative inefficiency is built into our private insurance-based system. It accounts for in excess of \$70 billion per year that is spent on insurance company overhead (underwriting, marketing, reviewing claims), and overhead costs for hospitals, doctors and other health care providers. Part of this figure is also attributable to billing expenses. A recent survey by Citizen Action² found that between 1981 and 1991, commercial insurance administrative expenditures rose 40% faster than benefits paid. Additionally, they reported that insurers spent 36.4 cents to deliver a dollar of benefits in 1991, seventeen times more than it cost Medicare (2.1 cents) and 40 times more than it cost the Canadian single-payer health system (0.9 cents).

Pre-existing conditions. Excluding coverage for pre-existing conditions is one of the most common practices used by insurers to limit their financial risk. Millions of Americans are unable to find health insurance coverage they can afford for the very illnesses for which that coverage is most critical. The number of pre-existing exclusions has skyrocketed and range from the serious to the very minor. The practice of excluding people with pre-existing conditions also locks these individuals into a particular job. If they want to leave their position, they risk losing their coverage and are not likely to obtain it again without at least a waiting period. Equally destructive is job lock-out, when qualified people with disabilities are unable to enter or re-enter the work force without jeopardizing their health coverage.

Underwriting practices/cherry-picking the "good risks." In insurers' efforts to minimize their exposure to risk and to maximize profits for their shareholders, insurers rely on medical underwriting. This evaluation is based on an individual or group's health history and potential for health problems. The industry has taken this practice to an extreme and carved out those groups who are "perceived" to be high risks. These practices create an especially stiff burden for small businesses, the self-employed, and individuals trying to purchase insurance coverage.

Regulatory failures at state level. The insurance industry has been quite successful in its effort to exert influence over the state regulation of health insurance. Individual companies and associations of companies use our consumer dollars quite effectively in their lobbying efforts with state regulatory bodies and legislatures. In some states, like Texas, health insurance is virtually unregulated and therefore consumers are not adequately protected from marketplace abuses.

II. POSITIVE FEATURES IN CLINTON PROPOSAL TO REIN IN INSURANCE COMPANIES

Essentially, the President's plan prohibits insurance companies from engaging in many of the practices outlined above, including cherry picking, cream skimming and other discriminatory practices. The President's bill clearly recognizes the most serious problems consumers face in the health insurance marketplace and attempts to address them. The best way to eliminate these problems is to remove the private insurance industry entirely from health care. However, if Congress is not willing to take such action, elaborate steps will need to be taken to restrain insurance companies from practices that discriminate unfairly against the very people who need health care the most. Insurance reform measures retain and add complexities into our already complicated system, but are absolutely necessary if private insurance companies are to remain the major payers. The insurance reforms recommended in the president's bill are similar to many proposals Consumers Union has long endorsed:

Insurance companies will no longer be able to use underwriting practices or pre-existing condition exclusions. The Clinton plan very clearly states that health plans must accept every eligible person enrolled by an alliance, regardless of individual characteristics, health status, anticipated need for health care, occupation, or affiliation with any person or entity. No waiting periods or riders that exclude certain illnesses or conditions will be permitted. Furthermore, health plans may not terminate, restrict, or limit coverage under the standard benefit package for any reason.

The Clinton plan's standard comprehensive benefit package will cover health care needs and facilitate comparison shopping. The plan provides a fundamental building block for a health care system that is intended to be accountable to consumers. Competition cannot work if consumers are ill-informed, misinformed, or confused. Standardization allows informed consumers to make clear comparisons among available plans and to make choices based on quality and cost. Uniformity among packages can help with consumer accountability and fairness. Everyone must understand what is and is not covered. Under the bill, consumers will be able to identify when a particular health plan is not fulfilling its responsibilities. Moreover, the bill

²"Premiums without Benefits, 1981-1991. The Continued Growth in Commercial Health Insurance Industry Waste and Inefficiency," October, 1993.

will curb the insurance practice of designing benefit packages based on risk factors—trying to attract low-risk enrollees and avoid costly sick enrollees.

Finally, the administrative simplicity of requiring a standard package should bring about some cost savings. A significant cost factor in our current health care system is the constant movement of people from one plan to another because their particular situation (job, health, location) has changed. Guaranteeing comprehensive and consistent coverage to everyone will eliminate some of these costs.

Alliance-prepared report cards will provide consumers with objective information about each health plan. While some organizations, like Consumers Union, try to help consumers sort through the mine field of fine print and complex terminology that laces today's health insurance policies, there is no universal system in place to help consumers objectively compare and evaluate these ever-changing products. The Clinton plan puts the responsibility for evaluating and comparing health plans squarely in the hands of each regional alliance. For the first time, consumers will have information presented in a uniform manner, including the cost of premiums and average out-of-pocket expenses; the characteristics and availability of the health providers participating in a plan; restrictions to access, the utilization review process, pre-approval requirements; and a copy of the National Health Board's annual quality performance report. The National Quality Management Program, to be created to collect and disseminate information about consumer satisfaction, should also provide information about consumer complaints, health plan dispute resolution effectiveness, and rate of health plan denials.

Community rating will make premium costs more reasonable. The bottom line for any kind of insurance is spreading risk: costs that would be excessive for one person can be spread across a group of people. The larger the group, the more predictable the total or average expenses are for that group. Larger groups also reduce administrative costs for insurance companies since there is no need to tailor the individual premium rate to the group.

Unfortunately, over the years, health insurance companies have moved away from the basic principle of spreading risk, preferring instead to minimize their exposure to risk. As health care costs have increased, insurance companies have carved the market into smaller and smaller groups and set premiums based on the actual or perceived health care costs of each group. Companies now compete intensely for the best risks, i.e., healthy people, by offering them lower premiums. Meanwhile, those in greatest need of health care—the sick, elderly, disabled—either cannot find coverage at all or face prohibitively expensive premiums.

Clinton's proposed community rating, whereby insurers offer insurance at fixed rates to all purchasers, is an appropriate remedy to the perverse yet pervasive risk aversion among health insurers. This concept, originally used by Blue Cross/Blue Shield, worked well until for-profit insurance companies began "creaming off" young, healthy groups by offering them lower rates based on each individual group's actual health experience, a practice known as "experience" rating. Community rating, on the other hand, treats all groups as if they belong to one large group, thus spreading the risk and costs more efficiently and fairly.

The risk adjustment mechanism is intended to remove the incentive to deny treatment to high risk groups. Consumers Union supports the concept in the Clinton proposal of setting up a mechanism through which all plans within an alliance will be required to spread the costs of high risk persons. Such a mechanism is essential to ensuring that the costs of high risk enrollees are not disproportionately borne by one plan whose over-utilization by plan participants or over-subscription of high risk people might threaten its viability.

Although the proposal leaves the methodology for risk adjustment within alliances to be decided by the National Health Board, it provides the Board with the authority to set up a mandatory reinsurance system to accomplish this goal. Consumers Union believes a mandatory reinsurance system is a useful approach to the dilemma of spreading the costs of high risk individuals among plans. The ability of an insurer to shift part or all of certain risks to another insurer helps that insurer share underwriting losses and enables it to accept all applicants for insurance. Our concern with this proposal is that it appears to limit the reinsurance pool to participating plans within each regional alliance. As a result, depending on the number of participating plans in a particular alliance, the contributions to the reinsurance system for each insurer may be quite high. A better approach may be to spread the cost throughout the entire system of alliances. Thus, those plans participating in a regional alliance where there exists a high incidence of a particular disease or infirm population will benefit from spreading the risk to health alliances in other regions.

The insurance industry will be subjected to FTC scrutiny. The insurance industry is regulated on a state-by-state basis, and federal oversight is minimal. In fact, under current law, the Federal Trade Commission is barred from even studying the

insurance industry except in response to a Congressional request. The absence of federal oversight has resulted in regulatory inconsistencies and lapses that are detrimental to consumers.

Placing the insurance industry within the scope of FTC regulatory authority will merely place insurers on the same footing as other financial service industries, such as banks, which are subject to an elaborate regulatory scheme enforced by both state and federal officials. National rule making authority over the insurance industry is an essential step toward ending the uneven and onerous state-by-state regulatory scheme. FTC consumer protection jurisdiction will ensure that insurance consumers can count on some federal oversight and protection.

Repeal of the McCarran-Ferguson Act. Unlike other industries, insurance companies are largely immune from antitrust laws. Under the McCarran-Ferguson Act, the "business of insurance" is exempt from federal antitrust laws except in instances of coercion, intimidation, or boycott. This special privilege allows insurers to engage in anti-competitive practices that keep insurance prices unreasonably high for consumers. Many industries, including electric utilities, telecommunication companies, airlines, and railroads, are subject to regulatory purview as well as antitrust laws. Each of these industries, though strictly regulated, operates in an open and competitive market. If we are going to permit the insurance industry to continue to have a role in the nation's health care system, it does not seem unreasonable to expect it to be more competitive and responsive to consumers. Repeal of the antitrust exemption will enhance competition to the benefit of consumers by prohibiting anti-competitive activities, such as price fixing and collusive division of markets, and encouraging efficiency among insurers.

III. RECOMMENDED IMPROVEMENTS TO CLINTON PLAN

Although we are still evaluating the full impact of the Clinton plan, we can suggest the following improvements:

The Clinton plan needs to make it easier for consumers to resolve complaints. The Clinton plan requires each health plan to establish its own claims dispute procedure, using "alternative dispute resolution procedures" with deadlines for resolution and early review of disputes by neutral third parties. If the grievance is not resolved by the health plan, consumers could pursue the issue with the alliance or through other legal remedies. The alliances are responsible for resolving consumer complaints, grievances, and requests to leave a health plan.

Moreover, as people move from plan to plan, they should be able to count on a similar process to resolve disputed claims. A grievance process would be fairer if consumers could use the same uniform process, regardless of where an individual lives or the plan to which they belong. Placing the grievance process at the alliance level, rather than the health plan level, also would facilitate alliance reporting to consumers on the various plan's records in resolving grievances—certainly an important issue to consumers who are comparison shopping. The process also should be easy enough for the average consumer to understand and use.

Each alliance should set standards for health plan performance, such as limiting administrative costs to the same level as the administrative costs of the Medicare program. Medicare has consistently demonstrated an ability to keep administrative costs at a minimum, while paying millions of claims for elder and disabled Americans. Holding insurers to the same level of administrative costs as Medicare would ensure that premiums are spent on health care coverage and not on wasteful administrative, marketing and other unnecessary bloat.

Strong protections against redlining at the health plan level must be included. Consumers Union supports strong provisions that would prohibit unfair discrimination in the health insurance marketplace. All insurance plans certified by the alliances should be available to all who seek them. Insurance companies should be expressly prohibited from refusing to offer or sell their plans to consumers based on race, color, national origin, age, gender or geographic location. Steep penalties should attach to violations of anti-discrimination provisions.

The supplemental market needs to be more tightly regulated. The Clinton plan provides a comprehensive set of benefits. But not all medical services are covered and the proposal calls for some out-of-pocket expenses. Therefore, we can anticipate a substantial supplemental insurance market, one, that if history is any guide, will need to be tightly regulated. However, the proposal falls short in regulating supplemental policies covering benefits in excess of those in the guaranteed package. It is essential that these benefits be standardized and community-rated. In addition, Congress should beef up regulation of the long-term care insurance market, where insurers have created a dizzying array of policies, riders, and features that confuse even the most diligent consumer. Some policies which are virtually worthless to con-

sumers, such as hospital indemnity insurance and specific "dread" disease policies, should be banned outright. With regard to supplemental policies which cover cost-sharing expenses, the President's plan establishes fairly comprehensive consumer protections, such as standardizing policies, prohibiting pre-existing condition exclusions, requiring community rating, and establishing a minimum loss-ratio of 90%.

We would like to see a clear, simple, and uniform grievance process for supplemental policies established within the alliances, preferably using uniform national guidelines. Data comparing the performance of supplemental policies should also be made available to consumers.

The Clinton plan should make freedom of choice of health care provider a real option for consumers at all income levels. It is choice of doctor that consumers care about, not merely choice of insurance company or health insurance plan. This is one of the most highly valued features that consumers seek in their health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other providers. It is not unusual for one family to have an array of providers, making it impossible to follow them all to one health plan. The Health Security Act has a new provision that will expand consumer freedom-of-choice of doctor: the new point-of-service option allows all HMO enrollees to seek treatment from non-participating providers. This is a safety valve for consumers who enroll in an HMO when healthy, but feel the HMO is unable to meet their changing health care needs. We continue to fear, however, that many consumers will be unable to afford the fee-for-service option. To make the fee-for-service choice viable to more consumers, the differential between the premium costs for fee-for-service plans and the average cost plan should be kept to a minimum.

IV. CONCLUSION

While we would prefer a system that does not rely on the insurance industry, we believe the Clinton plan addresses some of insurers' most glaring health care market abuses. We hope that Congress, as it considers various health care reform options, will strenuously regulate the health insurance industry.

The CHAIRMAN. Mr. Kahn.

Mr. KAHN. Good morning, Mr. Chairman and members of the committee.

I am Chip Kahn, executive vice president of the Health Insurance Association of America. HIAA is a trade association representing 270 commercial health insurance companies, providing insurance to over 65 million Americans.

Mr. Chairman, with your permission, I would like to submit my written statement for the record.

Mr. Chairman, I want to thank you this morning for the opportunity to appear before the committee. My remarks are based on our initial review of the Health Security Act. HIAA and its member companies are currently reviewing the plan and have not developed formal policy positions on all of its details, but I can comment on the major issues facing health reform in this committee.

Comprehensive health care reform is the Nation's highest domestic priority, and it should be. Thirty-seven million Americans are uninsured, and many others are without the coverage they need, particularly with regard to preventive services; while others feel they may lose their coverage if they change jobs or get sick.

Health care costs continue to spiral. The system needs to be reformed. We, the Nation's commercial health insurers, agree on this with the President, the Congress, and the American people, and we are ready to work with you to make change happen.

The President has correctly identified six principles on which true reform must be based: Security, simplicity, savings, choice, quality, and responsibility. We agree with the President and the Members of Congress who have developed reform proposals found-

ed on these principles. Clearly, we need structural, fundamental reform in our health care system.

HIAA has developed its own vision for health care reform, which is predicated on these same principles. Let me take you through where we stand and why I think we share so much in common.

First, the association is for cradle-to-grave coverage for all Americans; no exclusions for pre-existing conditions or previous illness; coverage that cannot be canceled if you get sick; if you change jobs or lose jobs, coverage that goes with you. Employers as well as employees both pay toward coverage. Subsidies for those who cannot afford premiums. We need to control medical liability lawsuits and unnecessary tests, and publish price and quality data. We should have a single claims form and more fast-moving and improved efficiencies in administrative costs. We need incentives for healthy lifestyles. We need assurance that Medicaid and Medicare will pay their fair share of costs in the system. And we agree with the previous panelists who stressed managed care as the future for controlling costs.

All of these items taken together reflect comprehensive change which meets the concerns of the American people, and the commercial insurance industry whole-heartedly agrees they are needed.

Mr. Chairman, the HIAA has several concerns, however, with some of the details of the Health Security Act, based on our initial reading of the plan and the earlier drafts of the plan that were made public. These are interestingly very similar to those raised in the previous panel.

First, mandatory purchasing alliances. Aggregating purchasing power is the intended objective of the health alliances in the President's plan. We certainly do not oppose this theory. The administration's bill require anyone who works for a company with less than 5,000 employees, and all people with individual health insurance coverage, to enroll in the new alliance structure. In essence, that means 80 percent of all Americans, roughly 200 million people, would be required to receive their coverage through an untested alliance system.

In a mandatory approach, where do Americans go if the system does not work as well as envisioned in the plan? The infrastructure that previously served them will no longer exist.

HIAA would favor having the Government establish purchasing alliances or cooperatives on a voluntary basis, as has been proposed in legislation. Under this system, employees and individuals would not be forced to purchase through the alliance. They would have the option of purchasing through the alliance or purchasing their coverage as they do today. All health plans, whether or not they participate in the health alliance, would have to play by the same rules, so that neither the alliance nor the plans operating outside the alliance would receive an inequitable share of the risk. Clearly, we have to do away with the kind of risk selection that was cited in the earlier testimony.

Insurance reforms such as elimination of pre-existing condition, limitations and guarantee issue of insurance, along with a risk adjustment mechanism, would be applied to plans offered both inside and outside the alliance. If health alliances are truly more administratively efficient and better at pooling risks, then the carrier oper-

ating through the alliance will have lower premiums and will naturally gain market share. A voluntary approach would provide the opportunity to test the theory of alliances.

Second, premium caps and price controls. While the Health Security Act may not contain the precise words, "global budgeting or national health care budget," nevertheless the concept is implicit throughout the bill. There is no question that the health care cost growth needs to be curbed. HIAA believes there are many ways to cut costs without cutting care.

The administration's proposal would, after a transition period, force insurers to constrain national health care spending at a rate no faster than the rate of increase in the Consumer Price Index adjusted by population growth. To achieve this, the plan would cap premiums charged to a weighted average premium.

Considering the dramatic growth in health care costs, as only partially related to price, such a target would be difficult to achieve without radically affecting either the benefits of services or the services people receive.

Implementing the President's plan also will require between \$30 and \$90 billion in new capital for health plans. Raising the necessary capital will be extremely difficult under premium caps. This was referred to in the previous panel. There will be no incentive for private investment in a price-controlled premium cap market. We think these caps will have a chilling effect on private investment and stifle price-lowering competition.

Mr. Chairman, starting down the road of price controls and premiums caps would, we feel, be a mistake.

Mr. Chairman and members of the committee, we support comprehensive health reform. You and Senator Kassebaum and members of the committee have shown great leadership in reform. We look forward to working with you in developing a comprehensive health care reform bill that achieves the objectives that we all share in common.

I cannot overstate our intent to be pro reform and to help be part of the solution.

Thank you.

[The prepared statement of Mr. Kahn follows:]

PREPARED STATEMENT OF CHARLES N. KAHN

Good morning, Mr. Chairman and Members of the Committee. My name is Charles N. Kahn III, I am Executive Vice President of the Health Insurance Association of America. HIAA represents approximately 270 commercial insurers covering approximately 65 million Americans.

Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform.

In his speech to a Joint Session of Congress on September 22, and again on October 27, President Clinton identified six fundamental principles on which any reform plan must be based: security, simplicity, quality, savings, choice, and responsibility. These are the same principles on which HIAA's own Vision for Reform was constructed last year. I would like to submit a copy of our Vision Statement for the record.

In communications with the Administration, Members of Congress, and the general public, HIAA has repeatedly stressed its wholehearted support for these principles, and has proposed specific means by which they can be implemented. Let me emphasize what we're for:

"Cradle to grave" coverage for all Americans.
 No exclusions for existing or previous illness.
 Coverage cannot be canceled if you get sick.
 If you change jobs or lose your job, coverage goes with you.
 Employers and employees both pay toward coverage.
 Subsidies for those who cannot afford premiums.
 Control malpractice lawsuits and unnecessary tests.
 Publish price and quality data.
 Single claim form to control paperwork.
 Incentives for healthy lifestyles. Emphasis on wellness and prevention.
 Stop shifting costs of Medicaid and Medicare to those with private insurance.
 Using managed care to control costs.

While the HIAA strongly supports comprehensive reform built on universal coverage, we have serious doubts about many of the features of the Administration's plan. In the broadest sense, the President's plan erects an enormously complicated bureaucratic structure which could undermine, not foster an improved system. The HIAA believes it is appropriate for the government to establish guidelines and rules governing a reformed system. We do not believe, however, that government should, in fact, run the system.

HEALTH ALLIANCES

The President's bill calls for the creation of large, government-mandated purchasing pools through which everyone, except persons employed by an employer with more than 5,000 employees, must purchase insurance. The theory underlying this concept is that a large pool of purchasers will have significant market clout to bargain for low-cost health care—market clout which small employers lack today. These mandatory government alliances will be responsible for contracting with State-certified health plans pursuant to the criteria established by a State under Title I, Part 1, Section 1203(a).

HIAA notes that the limitation on plan availability outlined in the Administration's September 7 "Working Group Draft" has not been retained in the bill. Under Title I, Part 2, Section 1321(a)(1) ". . . each regional alliance shall negotiate with any willing State-certified health plan" While this does reflect an improvement over the "Working Group Draft," we cannot conclude that it has necessarily addressed completely concerns over plan availability. Under Section 1321(b)(1) an alliance could reject a State-certified health plan if its proposed premiums exceed by 20 percent the weighted average premium within the alliance. We also believe the premium caps combined with the National Health Board procedures that determine a "national per capita baseline premium target" and the complex procedures detailing how payment to providers must conform, leads us to conclude that fewer plans will be offered.

All individuals and employers with less than 5,000 employees will be denied a key choice in the new system—they may not be allowed to retain their current insurance coverage or plan. Not all plans will be allowed to compete in the new system. What happens to those consumers who want to retain their current plan? Or purchase their coverage from an agent, who is, in essence, a benefits advisor to the employer? In a state which elects to establish a single-payer health care system, there will be no choices of health plan at all (Title I, Subtitle C, Section 1223(b)(2), page 111). This does not seem consistent with the goal of consumer choice or the goal of competition.

Proponents of these alliances suggest that significant administrative savings can be realized. HIAA believes such savings have been overestimated. Certain administrative functions must be performed by the alliance. These include plan enrollment, premium collection, claims payments, and fraud detection. Under the President's plan, enrollment is handled through the alliance. Today, employers handle employee and dependent enrollment. That cost is not reflected in their insurance premiums. Most employers send premium payments directly to the insurer or health plan. Under the President's bill, the alliance will not only handle enrollment, but will also collect the employer and employee share of the premium, forward premium payments to the plan selected by the employee, assemble and disseminate health plan marketing information, and negotiate fee schedules with providers. This can result in significant administrative expense for the alliance when one considers that everyone except employees of the very largest employers in the region must purchase coverage through the alliance.

The Administration characterizes regional alliances as simple purchasing cooperatives providing individuals and small groups with buying leverage in the market. Their alliances are not simple purchasing cooperatives. They are organizations with

huge budgets, considerable authority and a broad range of responsibilities. Laura D'Andrea Tyson, Chair of the President's Council of Economic Advisors, stated recently that the alliances will require 50,000 employees to operate them. The breadth and scope of activities of these regional alliances exceeds that of most existing agencies of state government today.

Health alliances are untested. The states that have authorized purchasing alliances in place have made them voluntary; only one is currently operational. The Administration's bill requires anyone who works for a company with less than 5,000 employees, and all people with individual health insurance coverage to enroll in the new alliance structure. In essence, that means that 80% of all Americans, roughly 200 million people [these numbers include everyone except 33 million Medicare beneficiaries and 20 million workers and dependents whose employers would be eligible to establish Corporate Alliances. Source: "Congressional Health Care Workshops" materials dated September, 1993], will be receiving health coverage through an untested alliance system. There is no precedent for such massive change to a process so essential to the welfare of all Americans. After all, according to a June 1993 "Harvard School of Public Health" survey, 77% of Americans surveyed are pleased with their health care coverage.

One alternative to monopoly health alliances are voluntary health alliances. HIAA would favor having the government establish purchasing cooperatives or alliances on a voluntary basis. Under this system, employers and individuals would not be forced to purchase their coverage through the alliance, they would have the option of purchasing through the alliance or maintaining their current coverage. All health plans, whether or not they participate in the health alliance, would have to play by the same rules so that neither the alliance nor plans operating outside the alliance would receive an inequitable share of risk. Insurance reforms, such as the elimination of pre-existing condition limitations, and guarantee issue of insurance, along with a risk adjustment mechanism, would be applied to plans offered both inside and outside the alliance.

If health alliances are truly more administratively efficient, and better at pooling risks, then the carriers operating through the alliance will have lower premiums and will naturally gain market share. If, on the other hand, employers and individuals prefer to deal directly with an insurance company rather than a large government bureaucracy, they would have that choice. The market, not the government, should determine which is the more efficient way to insure all Americans. A voluntary approach would provide the opportunity to test the theory of the alliance approach, without gambling the security and future of health care coverage for all Americans in the process. In a mandatory approach where do the millions of Americans go if the system doesn't work? The infrastructure that previously served them will no longer exist.

PRICE CONTROLS AND PREMIUM CAPS

While the Health Security Act does not contain the precise words "global budget or national health care budget" the notion of a national budget is implicit throughout the Administration's document. [See attached document "Budget Development and Enforcement (Premium Caps) for Regional Alliances in President Clinton's Proposed Health Security Act"] There is no question that health care cost growth needs to be curbed. HIAA believes there are many ways to cut costs without cutting care. Arbitrary price controls have never worked in our economy. The Health Security Act (Title VI, Subtitle A) directs the new National Health Board to set a baseline premium target for 1995. It then sets a national and local inflation factor for premiums in subsequent years. The inflation rate for premiums would be limited to no more than the CPI by 1998.

The HIAA commissioned the Washington National Tax Services of Price Waterhouse to compare the premium growth targets in the Administration's health care proposal and the actual growth in real per capita health care spending in twenty-four Organization of Economic Cooperation and Development (OECD) countries between the period of 1961 and 1991. Only four countries—Turkey, Ireland, Sweden, and Greece—held per capita health spending to a level that was comparable to CPI growth for one of the five-year intervals since 1961. Most countries have had rates of growth that are well above the rate of general inflation. In fact, during the most recent five-year period, three out of four OECD countries had growth rates that averaged 2.1 % higher than the rate of growth in the general price level.

Considering the dramatic growth in health care costs is only partially related to prices (no more than one-third), such a target would be difficult to achieve without radically affecting either the benefits or the services which people receive. The lion's share of health care cost growth is attributable to growth in the use of health care

services and the ever-increasing availability of new procedures and services. CBO issued a study last month questioning the efficacy of premium controls, saying they would have "undesirable consequences" such as "technological progress in health care would probably occur more slowly." "Effective limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies."

Henry Aaron and Charles Schultze of the Brookings Institution have noted:

"Growth of medical costs will be contained on a sustained basis only if we prepared to ration care to those who are insured and are able and willing to pay for services . . . Concern for fundamental values such as age, viability of an illness, and aggregate costs of treatment will inevitably shape our decisions on resource allocation. Physicians and other providers will increasingly experience tension between their historic commitment to doing all that is medically beneficial and the limitations imposed on them by increasingly stringent cost limits."

In the October issue of *Science*, Eleanor Chelimsky states that:

"Two other readily foreseeable affects of cost reduction on access and quality are the decrease in the amount of time physicians and surgeons can spend with patients, as well as a concomitant decrease in the number of real physician services per visit; and a corresponding increase in patient waiting time and in the number of visits required for appropriate medical care to take place."

As a country, we must decide if we are ready to ration access to health care for the American consumer. The budget and premium caps set forth in the President's plan will move us in that direction.

Implementing the President's plan will require significant new capital investment. Private estimates of new capital estimates vary all over the lot. The lowest we've seen is \$30 billion over the phase-in period; the highest is \$90 billion. These are hardly trivial sums. But, there will be no incentive for private investment. In a price controlled/premium capped market, companies will be severely impaired in their efforts to attract capital. Capital will be needed to organize the networks of hospitals, doctors, and other providers that are the core of the new system. Capital is needed to assure that health plans have adequate reserves to cover unexpected losses and guarantee solvency. The new system will require more capital than the current system, both to cover the 37 million uninsured, and to cover the many millions of employees who will have to shift from self-insured employer plans to fully insured plans offered through the health alliance system. Most self-insured plans are not likely to have any significant reserves to offset capital requirements. These capital requirements raise great concern about the solvency of health insurers. Over the last decade, the profit margin of the health insurance industry has averaged 1.75% [see attached chart]. With that narrow margin, if the premium cap is set too low and carriers are unable to cover submitted claims, insolvencies will occur.

Mr. Chairman and Members of the Committee, it is these concerns, combined with the bill's explicit limits on plan availability that are at the heart of our concern over that part of the President's plan that establishes mandatory purchasing alliances.

QUALITY AND CONSUMER PROTECTION

Title V, Subtitle C stipulates the procedures and steps that would be followed when a claim is denied. HIAA's preliminary analysis of this title finds that it establishes a detailed and complex regime that could substantially add to overall costs. For example, in addition to existing state regulatory bodies and the regional alliances themselves, the bill also provides for the establishment of complaint review offices in each state (Title V, Section 5202(a)(1)). Disputes reviewed under the procedures in the bill may also be reviewed by a newly created federal Health Plan Review Board (Section 5205). For claims involving a value of \$10,000 or more, a claimant may appeal the Review Board's decision in the United States court of appeals for the circuit in which the violation is alleged. In addition, the bill provides for the establishment of Early Resolution Programs which would permit a claimant to pursue non-binding mediation, binding arbitration or other forms of alternative dispute resolution as other alternatives for redress beyond those described above. It is unclear what, if any, purpose or benefit all these different forums and mechanisms would serve. It appears that all these layers will do is add unnecessary cost and confusion.

HIAA is concerned about the civil money penalties (Section 5206) allowed under the bill. In addition to attorney's fees and other "reasonable costs and expenses" stipulated in Section 5205(g), the President's bill would also permit the Secretary of Labor to impose substantial new penalties—\$25,000 per violation where a claim was found to have been unreasonably denied, \$75,000 per violation in the case of

a finding of bad faith and, in the case of a finding of a pattern or practice of violation, \$1,000,000 in addition to the other penalties. These penalties are both excessive and would contribute to escalating costs in the health care system and otherwise run contrary to the goal of containing costs. In addition to the civil penalties to the plans, individuals are conferred a new private right of action against a state for a state's failure to carry out its responsibilities and may recover compensatory and punitive damages. Both regional and corporate alliances are exposed to compensatory eligibility for premium discounts and cost sharing. We believe these additional damages will flow through to the health plans. In addition to the penalties being excessive the bill is unclear as to what standards would be used to assess such penalties.

The HIAA policy committees dealing with consumer protection issues have not completed their analysis of the Health Security Act so HIAA is unable to provide further detailed comments about this title of the Act at this time. However, in reviewing ERISA and various consumer protection bills over the last few years, the industry has developed several alternative proposals to address certain perceived problems under ERISA's current claims procedures. These three amendments to ERISA would: 1) shorten the claims process, 2) provide a fast, fair and user-friendly non-binding mediation process, and 3) provide for a civil penalty against plans and/or fiduciaries that engage in a "pattern or practice" of unfair claims denials. We believe these amendments (described below), together with the existing remedies in ERISA, are appropriate and should be a model for consumer protection.

EXPEDITED CLAIMS REVIEW

In general, the HIAA amendment would require that claims for medical surgical or hospital benefits be approved within 30 days of the filing completion date and that a full and fair review be provided within 30 days of the review filing date. Requests for pre-authorization would have to be approved within 30 days, and emergency preauthorization within 10 days, with the opportunity for a full and fair review of each within the same number of days as approval. We have concerns about the 24-hour expedited review process contained in the bill. The same time frames for approval and review would apply to requests for utilization review determinations and emergency utilization review determinations. The amendment also clarifies several definitions, including "preauthorization" and "utilization review determination".

NON-BINDING MEDIATION

The purpose of the amendment is to provide easy access to a fast, fair and user-friendly system to resolve claim disputes. The amendment provides that all claims for medical, surgical or hospital expenses would be eligible to go through non-binding mediation at the election of the claimant, plan or fiduciary. This would likely take care of a large percentage of cases while leaving both parties free to pursue litigation if they were not satisfied with the outcome of the mediation.

In general, mediation would be conducted by neutral facilitators identified and assigned by the Department of Labor. Mediation would be completed within 60 days from the final appointment of a facilitator with all reasonable costs divided equally between the claimant and the plan or fiduciary. All settlement offers and all documents and communications made during or generated in connection with the mediation would remain privileged and confidential and would not be admissible as evidence in any federal or state judicial proceeding unless all parties to the mediation consented in writing.

The amendment would also require every employee benefit plan to provide notice in writing to any participant or beneficiary whose claim for benefits has been denied of the availability of mediation at the election of either the claimant, the plan or the fiduciary under certain circumstances.

ADMINISTRATIVE CAUSE OF ACTION/CIVIL PENALTY

The amendment would provide for a new cause of action in addition to the removal of fiduciary remedy provided in Section 409(a) of ERISA for breach of fiduciary duty. The amendment creates a new right of civil action, solely available to the Secretary, to remove a plan administrator or other appropriately-named fiduciary, for a period of at least seven years, from a particular plan when clear and convincing evidence establishes that this person or entity had engaged in a regular pattern or practice of repeated claims denials made without any reasonable basis, and/or repeated violation of ERISA's established claims procedures. In addition, the Secretary may seek the imposition of civil penalties against the plan administrator or appropriately-named fiduciary in an amendment not to exceed 1) 5% of the agree-

gate value of claims shown by the Secretary to have been denied or unlawfully delayed or 2) \$100,000.

COMMUNITY RATING AND OTHER COSTS IN THE NEW SYSTEM

The administration's plan envisions the use of pure community rating to determine premiums, establishing separate rates to reflect family status. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices (non-smokers, for example). Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day? The young, who are least able to afford coverage and tend to use the system less, end up paying more in the new system. Regional alliance members will have to pay higher premiums to subsidize the additional costs of:

- Underpayment by the government for Medicaid eligible;
- Bad debts of people who don't pay their premiums (health plans cannot drop people for non-payment of premiums under the Administration's proposal);
- People who are currently enrolled in state-operated high-risk pools;
- Early retirees no longer covered by their employers' plan.

As this Committee is well aware, privately-insured patients pay higher prices in order to make up both for uncompensated care (the uninsured) and undercompensated care (Medicare and Medicaid). Universal coverage will all but eliminate uncompensated care, but the Administration's proposed method of financing its proposal will make Medicare underpayment much worse than it is today. We see no evidence that this effect has been taken into account in the Administration's estimates of likely premiums under its plan.

The HIAA has proposed specific means by which a reformed health care system can contain costs. In its Vision for Reform, the HIAA embraced seven mechanisms to help contain costs. We believe these mechanisms are basic to reform:

- Increased activity to combat fraud and abuse
- Administrative simplification
- Control of malpractice costs via medical liability reform
- Increased reliance on managed care
- Emphasis on personal responsibility and incentives for health lifestyles
- Emphasis on prevention
- Better access to management information

FRAUD AND ABUSE

We believe that the savings from anti-fraud activities are significant and warrant the insurance industry's continued vigilance. Each year we lose 10 percent of our total health care expenditures to fraud and abuse. That translates into an annual loss of nearly \$80 billion. If we stopped payment on \$80 billion in fraud, we could provide more than \$2,000 in health insurance to every American who currently has no coverage.

A recent survey on anti-fraud activities conducted by the HIAA revealed that the number of fraud cases investigated by health insurance companies increased by more than 75 percent in the last two years. During the same period, insurers reported a 150 percent increase in net savings from fraud investigations. For every dollar insurers spent in anti-fraud programs, they saved nine dollars. Two thirds of the reported savings from anti-fraud activities came as a result of detecting fraudulent cases before any payment is made.

HIAA believes that President Clinton's plan to combat fraud and abuse in health care will assist insurers in investigating and prosecuting fraud cases. In particular, the strengthening of federal penalties for those convicted of fraud, anti-fraud standards for electronic media claims, and increased government funding for anti-fraud enforcement will help insurers. In addition, the HIAA would like to see broad civil immunity that would enable insurers to share information about providers suspected of fraud.

ADMINISTRATIVE SIMPLIFICATION

HIAA recognizes that all administrative processes in the health care industry must be streamlined. We are committed to working with others in the industry to increase standardization. HIAA participated in, and wholeheartedly supports the recommendations of the Work Group for Electronic Data Interchange (WEDI).

We believe that electronic data interchange (EDI), commonly referred to as a "paperless claims system" can directly improve information exchange among all of the players in the health care industry. The benefits of EDI include better, more

efficient communication, improved patient care, and lower administrative costs. As the insurance industry has become more sophisticated and more responsive to the marketplace, EDI usage has increased.

HIAA believes the President's plan pertaining to administrative simplification will go a long way toward reducing administrative costs. We agree with the President; our health care system is awash in a sea of paperwork. We commend the President's recommendations for the standardization of reimbursement forms, the automation of insurance transactions, and the streamlining of Medicare.

MEDICAL LIABILITY REFORM

The costs of medical liability add significantly to the nation's health care costs. Physicians pay over \$5 billion in medical liability insurance premiums annually. Even more striking are the "hidden" costs associated with the practice of "defensive medicine" by providers threatened by lawsuits. A recent study found that the health care system could save \$36 billion over five years by eliminating defensive medicine practices. Medical liability affects more than just providers in the health care system. Liability costs also increase the cost of pharmaceuticals and medical devices. All of these costs are passed on to consumers.

HIAA supports federal medical malpractice reforms that will reduce the incidence of medical malpractice by improving risk management, recognizing the use of national practice guidelines as a valid defense against malpractice claims, and better policing of health care delivery. The HIAA would also like to see limits on extra contractual damages.

MANAGED CARE

HIAA believes that changing the health care delivery system is fundamental to reform. The delivery of care must be substantially better organized than it is today to meet the needs of consumers and providers. We believe that managed care can be a primary vehicle for achieving sustained system-wide cost savings.

A recent GAO Report concluded that there is insufficient evidence to demonstrate that managed care controls costs. The Health Insurance Association of America has reached a different conclusion. We believe that the success of managed care in the marketplace clearly demonstrates the value of managed care. In the last decade, enrollment in network based managed care has grown from a market share of 6 percent to 42 percent. The principal reason for this growth is that employers believe that managed care can help control their health care costs.

In addition, to growing popularity, there has been research that proves cost savings. From over two decades of studies by such noted researchers as the Rand Corporation and Hal Luft, there is convincing and consistent evidence that group and staff model HMOs reduce hospital use and costs by as much as 25 percent. These studies also found that the quality of service in the HMO was equal to the traditional fee-for-service systems with which it was compared.

Managed care systems should be permitted to pay providers in such a way to encourage quality and cost effectiveness. Providers should share in the risk of the cost of providing care, and should be rewarded for the cost-effective use of medical resources. New payment systems should be developed that encourage provider autonomy in decision making and reduce the micro-managing of providers that exists today.

Better relationships between providers and insurers will promote enhanced financial and managerial interactions, timely and responsive service to consumers and providers, quality management programs, and fraud and abuse prevention. The emphasis that managed care places on efficiency in the health care system should be reflected in the government's promotion of Medicare and Medicaid beneficiaries' participation in managed care.

PREVENTION

Because prevention promotes health and minimizes health care costs, the HIAA regards prevention as an essential component of health care reform. We applaud the inclusion of preventive services as part of the comprehensive benefits package in the President's plan.

Although improved coverage for preventive services will likely increase immediate demand for those services, demand for more intensive services will decrease long term. HIAA believes that coverage for preventive services is a long term investment that will benefit both the health of our nation's citizens and lower overall health care costs. For example, in a 1991 report to the Committee on Ways and Means, there are findings that for children under the age of 18, the uninsured reported 46 percent more hospital days per capita than the insured. There is a clear link be-

tween coverage for preventive services and primary care and decreased use of more intensive services.

INDIVIDUAL RESPONSIBILITY

No degree of access to medical services and no advances in medical technology can substitute for healthful lifestyles. We know that smoking is one of the single most preventable causes of death in the United States today. It is estimated that smokers experience \$6,239 more in expenditures on medical care over the course of a lifetime than non-smokers. Unhealthy lifestyles, violent crime, substance abuse, poor nutrition, unsafe living conditions, and the breakdown of families all contribute to health care costs.

HIAA believes that Americans must be rewarded for assuming individual responsibility for their own health. We support the use of financial incentives for individuals to engage in healthy lifestyles and are opposed to the President's proposal for pure community rating. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices. Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day?

BETTER ACCESS TO MANAGEMENT INFORMATION

Another aspect of individual responsibility is informed decision making by consumers. Consumers must be educated about how best to use the health care system, and individuals should have financial incentives to consider cost when choosing providers and using services. They must be informed decision makers. This can only be accomplished if they have access to useful information. HIAA supports the establishment of standards for the reporting of outcome and cost information. HIAA also supports the establishment of a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis. Dissemination of this information will: assist health plans in controlling costs and utilization, help managed care systems produce and evaluate outcome and cost data, and help a government-authorized entity develop guidelines that ensure that providers set consistent payment levels.

The information systems required to compile this data are extensive and will require significant new capital investment. In effect, in order to save money, insurers will have to spend money. While HIAA agrees with the President's proposal to enhance access to health care management information, we have serious concerns about whether, in a premium capped environment, insurers will be able to generate this significant new capital. Under the President's plan, premiums will be limited at the same time new and unpredictable demands are being made on health plans and insurers.

LONG-TERM CARE

HIAA is pleased to see that the Administration supports several provisions which would clarify the tax treatment of private long-term care insurance. These changes would greatly increase the affordability of these products and help millions of Americans protect themselves against catastrophic long-term care expenses.

If the Administration continues to promote the tax changes we seek, HIAA would also support the creation of federal standards for long-term care insurance products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. Equally important, consumers should be allowed to purchase federally-approved policies in all states; separate state approval should not be necessary.

We have two concerns with the newly proposed national home care program. First, a far better use of limited tax dollars would be to target care to those unable to protect themselves, and encourage those who can afford to do so, to purchase private protection. Secondly, we are concerned that the Administration will "sell" the public on this program as a down-payment toward a national solution to long-term care when even this modest home care benefit is estimated to cost \$80 billion over five years. Costs alone dictate that the ultimate solution must be a public-private partnership.

TRANSITIONAL INSURANCE REGULATIONS

The transition to a new health insurance market could take several years, especially if the new market structure is as unnecessarily complex and unwieldy as the President proposes to make it. The administration's bill specifies under Title XI, Section 11003 (a)(1) that "each health insurer that provides a group health insurance

plan may not terminate (or fail to renew) coverage for any covered employee if the employer of the employee continues the plan, except in the case of—(A) non-payment of required premiums, (B) fraud, or (C) misrepresentation of a material fact relating to an application for coverage or claim for benefit.” An identical prohibition is also set forth in the bill for individual health insurance plans.

We would oppose any attempt to prohibit insurers from withdrawing entirely from the health insurance business or any significant part of it, such as the individual market or the small group market. In a free country, government should not coerce any corporation or person to continue in any particular line of business.

During the transition the Secretary of HHS is authorized to set up a National Transitional Health Insurance Risk Pool funded by premiums and assessments against all insurers based on market share in the health insurance market. This constitutes yet another cost to insurers.

However, HIAA would support some of the proposed rules. In fact, they closely parallel insurance reforms we have been promoting at the state level for several years. I refer here to such requirements as guaranteed renewal of coverage, automatic acceptance of new entrants in currently covered groups, and portability improvements which prohibit exclusion of coverage for pre-existing conditions when previously insured people change jobs or their employers change carriers. These reforms can be implemented very quickly, and do not require a new bureaucratic structure the President proposes.

Other proposed transition rules present severe difficulties for insurers. The rules establish de facto premium caps by giving states the right to approve or disapprove rate increases as specified in Title XI, Section 11004. For reasons explained earlier in greater detail, we oppose limiting insurers’ ability to charge rates sufficient to cover the real costs of serving their enrollees.

There are also administrative problems with the proposed interim rating structure. It differs significantly from the rating reforms that have been enacted in more than half the states in the past three years and will therefore require significant time and administrative effort on the part of both states and carriers to implement, all for a scheme that would remain in place for a year or two.

In conclusion, I want to again emphasize that we support more of the President’s plan than we oppose. We want to be a responsible participant in the national health care debate and want to work with the Administration and Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system. During this discussion, we must remember that our health care system has many excellent features and we should build on them.

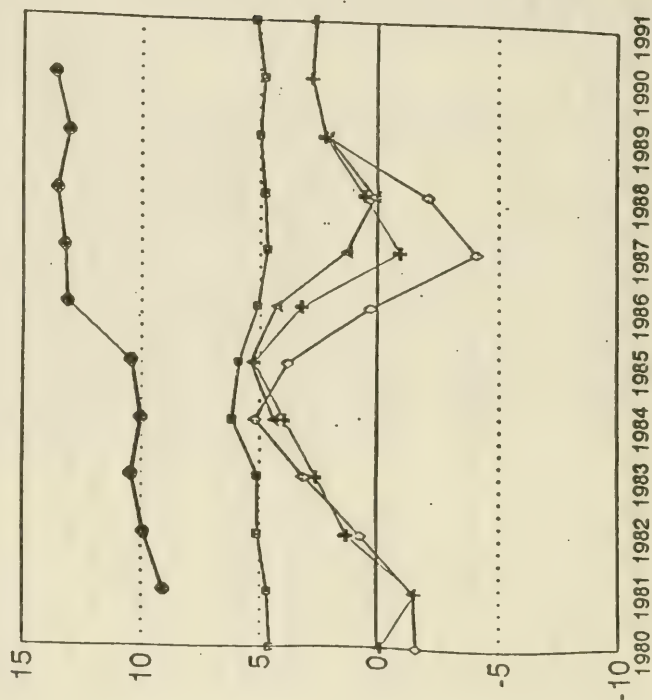
A Budget by Any Other Name: A Before-and-After Comparison

Feature	Working Group Draft*	Health Security Act
Draft uses term "National Health Care Budget"	Yes p. 93	No
Act sets annual rate-of-increase limits for premiums	Yes p. 94	Yes §6001 (a)
National Health Board (NHB) sets per capita premium target for each regional alliance (RA)	Yes p. 95	Yes §6003
Health plans bid and negotiate with alliances, which report final bids to NHB	Yes p. 95	Yes §6004 (a,b)
Alliance's weighted average premium must not exceed target	Yes p. 95	Yes §6004 (c,d)
If exceeded, NHB/RA reduce payments to plan whose premiums are over target	Yes p. 96	Yes §6011
Plans, in turn, reduce payments to providers	Yes p. 96	Yes §6012

* Page numbers are for the 9-7-93 Working Group Draft, the 239-page, 8 1/2" x 11" version, rather than the published book version.

PROFITABILITY OF SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES

1980-1991



TRENDS IN PROFITABILITY FOR SELECTED SECTORS IN THE HEALTH CARE AND HEALTH INSURANCE INDUSTRIES, 1980-1991

Year	(1) Insurance Company Operating Results (% of Prem)	(2) Hospital Total Revenue Margin (% of Tot Rev)	(3) Blue Cross Blue Shield Operating Results (% of NSR)	(4) HMO Return on Premium (Net Gain as % of Earned Prem)	(5) Pharmaceutical Manufacturers Return on Sales (Median %)
1980	(0.2)	4.6	(1.6)		
1981	(1.6)	4.7	(1.5)		9.1
1982	1.3	5.1	0.7		9.9
1983	2.6	5.1	3.1		10.4
1984	4.0	5.2	5.2	4.4	10.0
1985	5.3	5.9	3.8	5.4	10.4
1986	3.2	5.1	0.3	4.3	13.1
1987	(0.9)	4.7	(4.1)	1.3	13.2
1988	0.5	4.8	(2.1)	0.1	13.5
1989	2.2	5.0	2.1	2.1	13.0
1990	2.8	4.8			13.6
1991	2.6	5.2			

(1) HIAA survey of its top 20 members.

(2) AHA Hospital Panel Survey.

(3) Blue Cross Blue Shield net subscription revenue.

(4) McKinsey & Company, Health Care Payor Annual.

(5) Fortune Magazine, various issues.

BUDGET DEVELOPMENT AND ENFORCEMENT (PREMIUM CAPS) FOR REGIONAL HEALTH ALLIANCES IN PRESIDENT CLINTON'S PROPOSED HEALTH SECURITY ACT

1. The National Health Board (NHB) determines a "national per capita baseline premium target" for 1994, 1995 and 1996 by adjusting and trending forward actual 1993 expenditures for items and services included in the national benefit package. (§6002)

The legislation specifies in considerable detail the adjustments that are to be made to arrive at a fair presentation of per capita spending for alliance-eligible individuals. Whether sufficient data exist to make these adjustments is another question entirely.

2a. By January 1, 1995, the NHB determines a "regional alliance per capita premium target" for 1996. (§6003(a))

The alliance-specific targets are based on the "national per capita baseline premium target," adjusted to reflect regional differences in health care expenditures, percent of population un- and under-insured, and use of academic health centers.

2b. "Regional alliance per capita premium targets" for subsequent years are established by the NHB by March 1 of the previous year. (§6003(b))

After 1996, the new target equals the previous year's target times the "regional alliance inflation factor," also set by the NHB under §6001(a).

The "regional alliance inflation factor" equals a "general health care inflation factor" specified in the legislation (§6001(a)(3)), adjusted to take into account any material changes in the demographic and socio-economic characteristics of a particular alliance's population. (§6001(a)(2))

The factor may be reduced if the alliance exceeded its target in previous years. (§6001(d)) (See item 10, below.)

3. By April 1 each year, the regional alliance sends to prospective health plans NHB-specified information "necessary to enable a plan to estimate, based upon an accepted bid, the amounts payable" to the plan (i.e., actual revenue the plan will receive). (§1341(a))

Alliances must disclose to prove bidders the "regional alliance inflation factor" (§1341(a)(2)(D)), but may choose whether or not to disclose the actual per capita premium target (§6004(a)(1)(B)).

4. Bids from health plans for 1996 are due to the regional alliance on or before July 1, 1995. For subsequent years, bids are due August 1 of the previous year. In submitting bids, plans must agree to accept any premium reduction that may be imposed under §6011 (see item 7 below). (§6004(a))

5. If the state's plan permits it, alliances negotiate with health plans over premiums to be charged. After negotiations, health plans may submit new, lower bids. (§6004(a)(2))

Alliances are generally required to "negotiate with any willing State-certified health plan to enter into a contract" (§1321(a)(1)) but are not required to offer a contract if the plan's "proposed premium exceeds 120 percent of the weighted-average premium within the alliance" (§1321(b)).

6. By September 1, the alliance submits health plans' final bids to the NHB, along with information necessary to enable the NHB to estimate probable enrollment in each plan. (§6004(b))

7. The NHB determines a "weighted average accepted bid" (WAAB) for each alliance (§6004(c)), and compares it with the per capita premium target for that alliance.

If the WAAB exceeds an alliance's target, the NHB notifies the alliance on or before October 1. The NHB also notifies both the alliance and each "noncomplying plan" (i.e., plan whose final bid exceeds the target) of the "plan payment reduction" (i.e., the amount by which payment to the plan will be reduced below the plan's bid). (§6004(d))

After the first year, whether a plan is "noncomplying" is determined by comparing the plan's bid, not with the alliance's target premium, but with a plan-specific "maximum complying bid," which equals the previous year's premium for that plan, less any plan payment reduction for that year, plus the dollar amount (not percentage) by which this year's alliance per capita premium target exceeds last year's target or WAAB, whichever is less. (§6011(d))

Details of how the NHB will calculate the actual reduction for each noncomplying plan are specified in §6011(c). The reductions guarantee that the new WAAB for the alliance, after implementation of the reductions, will equal the target (unless actual

plan enrollment differs from pre-year estimates). The regional alliances implement the reductions when paying health plans under §1351.

8. Each "noncomplying" health plan passes on the plan payment reduction to its providers, both participating and non-participating. The method for calculating the amount of the reduction is specified in the legislation and by the NHB and cannot be changed by the health plan. Providers must accept the reduction and cannot charge patients more because of it. (§6012)

9. The alliance publishes the final information about premiums for each of its health plans, and other required information, and holds an open enrollment period during which individuals (family heads) choose which plan they wish to enroll in. Enrollment is effective January 1.

10. Once the final enrollment in each health plan is known, the alliance reports this information to the NHB, which calculates the "actual weighted average accepted bid" for the alliance for that year and compares it to the alliance's per capita premium target. (§6001(d))

If the actual WAAB exceeds the alliance's target, the "regional alliance inflation factor" for that alliance for the two succeeding years is reduced to make up the coverage. (§6001(d))

The CHAIRMAN. Thank you.

We will have 5-minute rounds for questioning.

Mr. Kahn, I listened to you, and I hear you, and you say so many of the words that I think most Americans want to hear, but as you well know, the American people have very little confidence in the insurance industry, based upon their own families' experience. That is the reality.

It can be shown in the statistics over here, that show the dramatic increase in the number of individuals who are not covered, in the purple lines. You are talking about rationing, but we see the people who are not covered and those who are denied any choice whatsoever escalating and continuing to escalate. In my State, 50,000 people lose their health insurance every month. There are 700,000 people who are not covered. And that number has been increasing across the country.

You talk about getting a handle on health care expenditures, and you look at the escalations in the costs. You talk about pre-existing conditions.

You should hear the testimony that I heard in Lawrence, MA yesterday of individuals who are basically excluded from insurance coverage, who had an illness; their insurance premiums went up, and then the employer eventually dropped these people, leaving them with no coverage at all.

And you say that you are ready to work with the administration, and yet, every morning, every afternoon and every evening, we look at those ads that talk about the administration's program "rationing", and that talk about the administration's program in terms of cost, which are effectively, I believe, a serious distortion and misrepresentation in terms of what the administration's program is all about.

I know there are differences of opinion about the administration's program. There is wide diversity on this very committee. But nonetheless we see these representations at the start of a national debate which is complex and difficult.

But these figures represent real working families. They represent tears in the eyes of mothers who are concerned about their children. They represent individuals who have cancer today and will not be able to live very long because they have been excluded from any kind of reasonable treatment.

That is what is happening in this country today, and we are reading your ads; we are listening to these ads. Now, I do not question your integrity and your own personal desire to try to be responsive to these issues. But I must say in my own State, people are watching these ads, and they are getting scared. They are already scared. They are frightened. They are frightened for their families.

How much are you spending on these ads?

Mr. KAHN. Around \$6.5 million, Senator.

The CHAIRMAN. Six-point-five million. And does that come out of premiums of people who even today have health insurance?

Mr. KAHN. Well, the companies in HIAA are mostly large, diversified companies which have many lines of business including health, yes.

The CHAIRMAN. And do you intend to continue those particular ads that talk about rationing and talk about choice, when we see what is happening to these families all over the country?

Is it your position, as you are reviewing the administration's proposal and how you intend to work with the administration—is it your position now, before our committee, to say that you are going to continue those ads, and you are going to have others as well?

Mr. KAHN. At this point, Senator, the only plans are to continue the ads through Thanksgiving. And the purpose of the ads was to raise certain issues which we thought would be of concern to people about the details in the plan—the health alliances and the financing of the plan—issues which you have got to consider.

The CHAIRMAN. Do you think that people are not concerned about their own coverage today? Do you not think that they are already scared to death, those who are covered, that they are going to lose their health insurance? Do you not think there is a family in this country that does not worry whether they are going to have the next \$5, \$10, \$50, or \$100 to fork out in an emergency room? Do you think you have to scare the American people to raise those kinds of concerns?

Do you think you are bringing light, or do you think you are bringing heat to this issue?

Mr. KAHN. Senator, we are in favor of reform. We agree with you that those people need to be assured of coverage. We think that there are issues that they need to think about as the legislation goes through the Congress. But we want the legislation to go through the Congress; we just want it to be fiscally sound, and we want them to have access to health insurance coverage that they like.

Let me point out that the President has made it clear that he wants the private sector, in partnership with the public sector, to work and make health reform happen. He wants private health plans to cover people.

We have some concerns under the structure under which they would be offered. That is what we have been raising in some of those ads, or whether the money will be there to provide the coverage.

And we have never mentioned rationing in any of the ads, Senator.

The CHAIRMAN. Well, you can watch those ads, and certainly everyone has watched them, and the very clear implication these ads make is that people are going to lose under this program, that they are in real danger of losing their coverage.

Let me ask you this. If you are interested, and if the companies and the associations are interested, why not drop the ads and try to work with us?

Mr. KAHN. Well, Senator—

The CHAIRMAN. Why not drop the ads and come and work with us, like the doctors and the hospitals, like many of the business associations, and many of the consumer groups? Why not drop those ads and come and work with us? Why not respond, as the President and the First Lady have reached out to try to get bipartisan support, to take all individuals and bring them inside the tent? Why not drop those ads and come and work with us?

Mr. KAHN. Well, Senator, we have been interested in that from the very beginning.

The CHAIRMAN. I am asking you why don't you drop the ads so we can at least try to work together.

Mr. KAHN. Well, we are continuing them through Thanksgiving, and at that point, we are going to reassess their usefulness.

Let me point out, though, that on the 22nd of September when the President spoke, and gave a great speech, our chairman, Dave Herd, from The Principal and Bill Gradison, the president of the association, talked with Mr. Celeste and said, gee, we believe our ads characterize problems with the President's plan, but we understand they bother you, and we are willing to pull them down, which was done, but we expect that there is going to be a different attitude toward insurance and more discussion. And nothing happened after that date. The heat from the administration was sustained, and the criticism, and our members felt they had to take their message to the American people and to the Congress, and the advertising was one way to do that.

You know, the very decision to do the advertising in the first place came with leaders of the association sitting around, looking at the 47-page document that was sent to the Hill back in August, prior to members going on recess, from the administration, describing their plan, full of inaccuracies and mischaracterizations of the role of the health insurance industry. And the members felt that they had no choice but to take their message directly to the people, and that is why they did the advertising.

The CHAIRMAN. Two further questions.

How much do you intend to spend to Thanksgiving—how much more?

Mr. KAHN. The number I gave you was the money that carries us up to Thanksgiving.

The CHAIRMAN. And do you intend to stop at Thanksgiving?

Mr. KAHN. Yes, sir. At that point, we are going to reassess the advertising schedule for next year. We have no advocacy plans yet, specific advocacy plans, for next year.

The CHAIRMAN. My time is up. My only point is that there are many doctors and providers, who have very serious concerns about this program; thoughtful men and women who have dedicated their lives to providing health care. Many doctors, many hospitals, are

very concerned about what this is going to do. There are many senior citizens who are concerned about whether there will be more of a gain with prescription drugs and some home health care. Many people are concerned about those issues.

There are many people who really wonder whether hard-working men and women in terms of this program are going to be looked after in a fair and just way. I could name all the groups, and you know them as well. None of them are out there trying to distort or misrepresent the President. Only one group, only one group, and that has been the backbone of the collapse of the health care system for so many individuals in this country, particularly those with pre-existing conditions and those who have lost their jobs and are out of work. Those statistics say it all. There is only one group that is doing it, and doing it out of the premiums of the individuals who have bought their program and are paying extraordinary costs for it.

I must say that when you say you want to work with the administration, and we look at all the other groups that say they want to try to see if we can find some common ground, there is only one group, your particular organization—as distinguished from those who have been here representing the insurance industry on managed care and other programs—whose sincerity has to be suspect.

Ms. MCGIFFERT. Senator, could I comment just real briefly? I think not only in the ads, but at the local level, the kind of sentiment that has been expressed here today is not coming through the people who deal with regulatory issues.

The insurance companies are still doing these practices. They are encouraging it. They are trying to do everything they can to keep health plans that have been developed by legislatures to cover high-risk people. And I know a lot of you are talking to your constituents, and you know people are being excluded. And I wonder why the insurance industry is not doing something about it, instead of just giving this lip service to it.

The CHAIRMAN. I will let you respond to that comment briefly, and then I will yield to Senator Jeffords.

Mr. KAHN. Thank you, Senator.

We need market reform; until you change the rules of the market, risk selection is still going to be an issue. That is why we are for reform. That is why we think the Congress needs to take on this issue. Only if we have the kind of reform that many members have suggested in their bills can we get around this issue of selection.

These companies are doing business, and they do not have much choice right now. In a reformed market, we think there will be a level playing field, and you will not find these practices anymore.

Thank you.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

I would like to follow up in this sense, to take a look at the options that are available under the Clinton proposal and others as to how we can get costs under control and as to what the methodology ought to be with respect to the plans which would be allowed under the Clinton proposal.

There are options, as you know. The experience of the current health care system has demonstrated that the variability in provider payment rates inevitably leads to cost-shifting—Medicare and so on. So I want to get your thoughts on the various options and what impact they would have upon your participation in the Clinton proposal or other proposals.

One, of course, we have set per capita payments into the alliance, and then let the alliance and the people in it select the various options. Another, of course, is with the variable premiums and the premium caps and so on. But I would like to get a little provincial here. In Vermont, the State is seriously considering an all-payer rate-setting system when it passes its reform plan. As you know, an all-payer rate-setting structure would require all providers to be paid at the same rate. Any managed competition in our State then is likely to be based on quality and efficiency instead of price.

I would like to know your views on that approach relative to some other approaches and how it would impact on the one hand the industry, Mr. Kahn, or the consumers, Lisa.

Mr. KAHN. We believe firmly that for costs to come down, there has to be some price sensitivity, whether it is on the front end, when people are paying premiums, or on the back end, with coinsurance, deductibles, and other means to make them cost-sensitive when they are purchasing their health care as well as when they purchase their health plan.

So we think you ought to have an environment where there is private insurance health plan competition, where people will be sensitive to price.

We believe that the private insurance industry has played an important role in covering people in the United States. I mean, 182 million Americans are covered by private health insurance. And the question in reform is how can we improve the system so we pick up the others and give security to the 182 million.

Clearly, costs have to come down, and we think, as was pointed out in the previous panel, that making health plans more competitive, building networks, encouraging doctors to practice more conservative medicine, is the way you bring about the kind of structural change that will bring the savings we need.

I do not have confidence that the setting of a price by Government will necessarily save any money. For example, in Medicare, in the 1990 budget bill, there were cuts that equalled \$35 billion, and those were carried out primarily through reducing prices. If you look at what has happened in the interim and what CBO's numbers tell us now, actually, Medicare spent over that budget period \$51 billion more than was expected rather than saving \$35 billion from what was expected. So much for price controls as applied in the Medicare program.

So I guess the point is I think you have got to change the structure. Just setting prices is not the way to go.

Second, one of the primary reasons we ran the ads is because we do have concerns about the funding of the bill. In these health alliances, we are talking about a constrained premium, but we are also talking about for Medicaid beneficiaries paying 95 cents on the dollar or less for the premiums going in for Medicaid beneficiaries.

We have real fears about whether sufficient money will be there, and I think as the bill is considered in the Congress, you have got to look at all of these different aspects. Whether it is subsidies for small business, or the money that goes in for the Medicaid beneficiaries who will be covered by the health plan, or the limitation on the private sector premiums, we are concerned that there will not be sufficient money from the get-go to make the thing work. And that is why we raise the issue in the ads.

Senator JEFFORDS. Just a follow-up. Is the problem with setting specific rates that you do not have utilization control? Is that the basic problem, or are there others?

Mr. KAHN. Well, if you look at what drives health care costs up, about one-third of it is inflation; another small percentage is demographics and the change in the population. But the lion's share, 45 or 50 percent, comes from new technology, greater intensity, medical prices going up because of changing products in the marketplace. That is the driving force. And the question is how are you going to bring that down, and how are you going to bring it under control without undermining quality. And our point of view is that the only way to do that over the long run is through structural change through managed care. Going to a single-payer system where doctors can remain sort of free agents out there, and hospitals can continue old practices, in our view is not the way to bring costs down. We have got to have networks, and we have got to have the organized care that was discussed in the earlier panel. That is for the long run the only way we will save money.

Senator JEFFORDS. Lisa.

Ms. MCGIFFERT. I would just say that certainly, a single-payer system approaches health care reform in a systematic way and looks at keeping the costs in check through fee schedules and planning procedures and limiting the unnecessary use of high technology or other care that is so prevalent in today's market.

I think that we have to approach this issue universally, and what we have seen in the past is that as we approach it piece-by-piece, we have had this constant cost-shifting. When Medicare prices or payments are reduced, it cost-shifts onto other people, and eventually affects the cost to Medicare.

So until we are all sort of playing by the same rules, we are not going to be able to keep these cost increases in check, and we believe that everyone needs to contribute to that.

We do know, though, that without premium caps in our current system, we have reached a point where the insurance industry basically provides a product that is unaffordable to most consumers, especially those who need it the most.

Senator JEFFORDS. My time is up. Thank you.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Mr. Chairman, I got here late because of a personal matter, but I want to tell you how much I appreciate your holding this hearing on the role of the insurance industry in health care reform.

I am frank to say to you that I do not believe the insurance industry ought to be involved in this entire area. Although I am a cosponsor of the Clinton bill, I must confess that I am teetering as to whether I should get off or not.

I think this plan ought to be operated by the Government and by the health alliances, and there is no reason for the insurance industry to be in this area at all. And although the President's plan calls for 12-1/2 percent as a maximum cost as compared to the present 25 percent that insurance companies are taking for sales of insurance, as well as administrative costs, overhead, and profit, that is a step in the right direction, but frankly, I do not believe the insurance industry serves a useful purpose in this area.

It is no small secret that managed competition did not just happen. It was a design by a select group of health policy academics in conjunction with the country's top insurance companies, and the company CEOs. And they sat down and worked on how to keep the insurance industry in this whole new concept of health care.

Mr. Chairman—well, the chairman is not here right now—

Senator DODD. Howard, you can talk to me.

Senator WELLSTONE. Howard, turn this way. I like what you are saying. [Laughter.]

Senator METZENBAUM. All right. Senator Dodd, you and I were strong supporters of Senator Kennedy when he first came forward with health care plans many years ago. So we believe in a health care plan for the people of this country. But the fact is you do not need the insurance industry in this field. It is ironic, as a matter of fact, that the very industry that has led us to the brink of disaster in health care is proposing that they should be given another chance to run the system.

Over a period of years, we have put the insurance on a pedestal. We had tremendous respect. We talked about the strength of "the rock." Well, the rock is not quite as strong as it was in yesteryear. As a matter of fact, the insurance industry has not earned any awards for fairly treating consumers, and as a matter of fact, they certainly have not earned any awards for the manner in which they have treated their policyholders.

Administrative expenses are obscene, averaging 25 percent of health care spending. And they have ripped off consumers in other areas as well. Prudential recently, in today's paper—this has been news for the last several days, but it hit the front page of The Washington Post today, that the Pru was going to pay \$360 million as a down payment for violating a consent decree in which they had promised to stop defrauding consumers purchasing certain limited partnerships.

Metropolitan Life—there is a wonderful case—the great Met that everybody has respected over a period of so many years is now under tremendous attack by the insurance commissioner of the State of Florida for defrauding thousands of nurses by promising a market rate retirement plan which frankly was nothing more than a whole life policy. So the State of Florida is on top of that matter.

Mutual of New York has gone bankrupt. I am not sure about Mutual of New Jersey. And over the past decade, almost 200 life and health insurers have gone bankrupt, including Executive Life and others, leaving hundreds of thousands of consumers high and dry. And although there has been talk about, well, they were protected because they had these State funds, the fact is in previous hearings, we have shown that something like 80 to 90 percent of

those State funds that had bailed out the insurance companies and helped the policyholders in those instances where they were helped, those were taxpayers' dollars. They were not the companies' dollars. They were deducted from the amount that the companies owed the States in taxes.

Their track record, in my opinion, could not be worse. And what are we doing? We are moving the entire health care program into that area. And notwithstanding that, you are spending \$6.5 million to fight it, and I am not sure how much more.

Now they are seeking to take over the health care delivery systems, and they say, "Trust us." They say, "We know better." They say, "We know how to do this. We know how to manage health care."

I have very little confidence in a health care system run by the insurance industry. I am not saying that all insurance companies are bad, but I am saying enough insurance companies are bad, and enough of them have ripped off the American consumer in health care areas as well as in other areas that we do not owe it to them to now give them this cream that has been worked out and called managed competition, which they developed and sold to the administration.

I know the Government has its problems, but I am frank to say I would rather have the Government paying the bills than the for-profit entities. The fact is Medicare costs a lot less to administer than do the insurance company costs.

Mr. Kahn, most small and medium sized insurance companies have very high administrative expenses. Some actually go as high as 40 percent, because they spend so much on underwriting and selectively marketing their policies. Isn't it a fact that many companies pay 100 percent, and in some instances more than 100 percent out of the first year's premium in commissions to their salespersons, just for selling the policy?

Mr. KAHN. It may be, Senator; I am not sure. On average, our expenses are lower than 25 percent. In the small group market for small employers—

Senator METZENBAUM. Why don't you just answer my question first?

Mr. KAHN. I have to check on it, Senator. I do not know the answer to the question.

Senator METZENBAUM. Aren't you aware of the fact that some insurance companies pay 100 percent and some actually pay 105 percent of the first year's premium to the salesperson who places the contract? You are aware of that, aren't you?

Mr. KAHN. I am not aware of it in health, Senator. I would have to check to see. It may happen in other areas. I am not aware of it in the health line, but I would be happy to check and get back with you.

Senator METZENBAUM. All right. Go ahead.

Mr. KAHN. I wanted to say that there are a range of administrative costs. For large firms, they tend to be down in the 5 or 6 percent range; for smaller firms, they are generally around 18 or 20 percent. Sometimes, they do go as high as 40. And clearly, we need to bring that down, and we think in reform that can happen.

Let me also say a couple of other things.

Senator METZENBAUM. Would you tell me which companies have only 5 or 6 percent in administrative costs?

Mr. KAHN. The insurance companies that are administering large plans, primarily self-insured plans, are down at 5 or 6 percent.

Senator METZENBAUM. That is where they are just administering the plan, which is being operated by some separate group such as a union and a company or companies?

Mr. KAHN. Yes, sir. So the costs vary. And that is about half the market is administration of self-insured plans. The other half of the market is split and has a variation of administrative costs depending on the nature of the products being sold.

But let me add that back in 1965, when insurers were mostly in the business of paying bills, where did the Government look when it needed to quickly put the Medicare program in place and get the bills paid? It looked to the private health insurance agency, Blue Cross and the commercial insurers at the time, and they are the ones that Medicare for its entire history has been using to pay bills. Now the role of insurers, as was described in the previous panel, is changing, because we do need to manage care and bring costs down through getting at utilization of services and changing the practice of medicine.

We believe we have a role to play, and I cannot sit here and justify all the practices in the past. All I can say is that what we are willing to do now is play a role in the change, and we think the President has recognized that in his legislation.

Senator METZENBAUM. You are willing to play a role at a 12-1/2 percent administrative fee; is that it—or do you want more?

Mr. KAHN. Well, there is going to be some cost to running the system, sir, whether it is 12 percent or 2 percent or 5 percent. But we think we have a role to play in keeping costs down, yes, sir.

Senator METZENBAUM. My time has expired, but I would just like to finish by saying I think that you have played a role in causing costs to go up, and I am afraid that you will continue to do so if we let you have a piece of the action.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Gregg.

Senator GREGG. Well, I take it we are no longer functioning under the 4-minute rule.

The CHAIRMAN. Well, Senator Metzenbaum came in—I do not know whether you were here—and yielded his time from the previous questions. He indicated that he wanted to have the additional time here, and I exercised the discretion of the chair. He could have either used the time there or here, so we recognized him for that period of time, and we are glad to extend that same courtesy to any of the members.

Senator GREGG. I do not care how we do it as long as we are consistent.

The question of promotion of plans—I am neither defending nor attacking the insurance companies—but let us be honest about the presentation of these plans. The administration has been extraordinarily aggressive with taxpayers' dollars in promoting its plan.

I would begin with this little pamphlet which was put out, which was not the plan; it was their summary of what they thought the plan would be. That little pamphlet cost us a few million dollars.

Then they followed it up with this little pamphlet, which they have sent to every——

The CHAIRMAN. Is that the Penguin Books plan?

Senator GREGG. Yes, and as it was distributed to us, it was not Penguin Books, if you will recall. I am sure you received a copy of it, Mr. Chairman.

Then we got this one, which has been sent to all the libraries in America, which was described to me this morning I think very accurately by a press person when they said it was a press release with a soft cover on it.

And then we got this one, the Health Security Act flyer that was put out by the Small Business Administration, for which we still have not been able to get a cost accounting.

And then we have the Democratic National Committee, with \$10 million in this program.

So when it comes to promotion, certainly the administration has been aggressive, which they should be aggressive—I mean, this is a complex, difficult issue which needs explanation, and it needs to have these pieces of information in the public's hands. But I do think that when other people who are impacted by this decide to join the fray, and the ball has been kicked off by the administration, that it is reasonable that they should be allowed to join the fray and not be berated for doing such.

In addition, there is a question here of what the role of insurance is and what the impact is on the process. I would take, for example, the President's own plan. As I understand the plan, if under global budgeting—and they do not use the term "global budgeting"; I presume that they are not trying to mislead anybody; of course, they are using global budgeting in substance—but when they set up this estimated cost per individual of premium, which they have not really named, if the alliance in a State—if it is a single-alliance State—ends up with the premium costs exceeding the global budget assessment which that State has available to it, then the national board can assess a fine against the alliance, and the alliance in turn assesses a fine against the insurance companies or the HMOs or whomever else happens to be providing the service, and you end up with a very ironic situation which means that those companies have to pay, which means you create an atmosphere within the President's own plan where, as I see it, there is significant pressure coming from this seven-member national board on the local health-providing group, whether it is an HMO or whether it is an insurance company, significant pressure to put pressure on the consumer not to use the benefits because that is the only way they are going to be able to pay the fine if they reduce the fine below the reasonable cost of the premium. It is the most unbelievably—not most unbelievably—but it is an unbelievable mechanism directed right at the premium and right at, in turn, the consumer who is going to get pressure from his HMO or his provider group not to use certain activities. And I presume it is also going to significantly circumscribe capital formation, R and D activity, and outreach for new technology such as we heard this morning this boy needed from Holland. So that brings in the whole issue of insurance, and I would appreciate some comments on that.

The second area I would like to get your comments on is what is the practical effect on the insurance process of the huge cost shift that occurs again—not in this plan, because this does not explain it, but we have the 1,300 pages running around here somewhere—of the fact that the Medicaid is capitated in a way that if a State is not paying the full cost of the premium of the Medicaid, the States pay what the capitated rate is. And let us take an example of if the premium cost is \$2,000, and the Medicaid is capitated at \$1,000, the State will have to pay \$950. That \$1,050 difference has to be picked up by the other insurance providers and health care providers, and what does that do to the premium costs? It again skews the marketplace because again you will have pressure and cost-shifting which will reduce quality of care, I presume, and inevitably reduce the consumers' availability.

So I would be interested in your comments on those two views, Mr. KAHN.

Mr. KAHN. Senator Gregg, I think this brings up one of our primary concerns, which is the whole funding of the plan and ultimately the actual premium that the national health board would set is based on the assumption that there will be a bunch of savings from Medicare, from Medicaid, and other programs, that they are going to make money available. And the trouble is that we are going to be stuck with whatever the number the Congressional Budget Office produces and says that is what the premium has to be to assure that everybody gets coverage.

And if we look at past experience with this, and Medicare catastrophic, which I know you were involved in one way or another, it started off in 1988 with an estimate of a \$30 billion cost, and it ended up in 1989 with an estimate of a \$48 billion cost for the first 5 years. And what happens if the same mistake is made? And this is only one little piece of the health care system; it is not the whole trillion dollars.

So our point is that the whole structure of the bill is sort of a house of cards which depends on a premium being guessed at right from the get-go, and if it is wrong, then what happens to the funding? That is our question.

Senator GREGG. But more importantly, if they are wrong, what happens to the consumer?

Mr. KAHN. Well, that is right, because if there is not enough money to pay for the plan—and what happens to the taxpayer, then? And if you listen to the administration testifying in front of Energy and Commerce Committee last week when this question was asked, they said, well, the Congress will act and do the right thing.

Well, our only concern is that you should not set up a program in which you have got to depend on Congress doing the right thing some time in the future. It should be a program that from the get-go has the financing structure in it that everyone can be confident of.

Ms. MCGIFFERT. I would like to comment on that. Certainly when you are managing care, you have to be sure that you are actually managing health care on the consumers' behalf as opposed to simply managing costs on behalf of an insurance company's shareholders. And when we do put the insurance companies in

charge, they are first and foremost looking out for their shareholders.

I would also like to remind everyone that we are picking up many of those costs now in all the various different programs on the Federal, State and local level. We have to acknowledge as a country that we are paying for that now, and we have to approach it in a systematic way so that people get the care that they need.

Senator GREGG. My time is up.

The CHAIRMAN. Senator Dodd.

Senator DODD. Thank you, Mr. Chairman.

If I can, let me just pick up on a few points. First of all, I think it is important—and Mr. Chairman, you made reference to it, which I appreciate, and others did as well—to note that there are distinctions here, and to lump all insurance companies together is really rather foolish. There are very significant differences, and I am offended when I hear this sort of “one size fits all.” We hear that about health care proposals, and it is just as offensive when it is applied to an industry that is extremely diverse. I think that point was made earlier by the first panel.

Now, Mr. Kahn, you are correct when you say that to run television ads is your right; I am not necessarily going to suggest that you should not be on television. What concerns me is that the ads appear to be misleading and create fear unnecessarily.

Your opening statement to this committee was that the President’s plan is not yet complete. As we all know, it is moving and changing as a result of hearings and suggestions and ideas. I think that is an accurate statement, and yet the characterization included in the TV ads leads the average person, I think, to believe that, in fact, the President’s plan is in concrete. I also believe there are misleading statements, in my view, in them.

I have the transcripts of these ads, and just in the area of caps, again, creating the scene—I think all of us have seen them—the person says: “Like the national health care budget. The Government sets a ceiling on spending and says that is it.”

And then, Libby: “But what if there is not enough money? I mean, what happens then? There has got to be a better way.”

Well, in fact, the bill does address the problem of a plan running out of money. On page 102, Title I, Subtitle C: “Participating States shall assure that in the event of failure of a regional alliance plan in the State, eligible individuals enrolled in the plan will be assured of continuity of coverage for the comprehensive benefit package.” And then in the very book itself, it goes on and talks about what happens.

You leave the impression clearly that this has not even been considered, and that is it. In fact, there are ideas. You may not agree with them, and there are legitimate points of disagreement. But to leave the impression with the viewer on television that no thought has been given whatsoever to that kind of a situation clearly has a damaging effect.

Now, at the end of the day, you might disagree with the Clinton plan; that is your business, and that is perfectly legitimate. But at this juncture to leave the impression with consumers that this plan does not take into account that kind of problem is misleading, in my view.

So put your ad on television if you will, but to mislead the consumers and to mislead the American public about what is in this plan, what thoughts have been given to those contingencies, that is what I find objectionable.

Now, on the issue of choice, the same thing. On this point, there is legitimate debate. And again, you make the case with Louise and Harry—I do not know where you got those names——

Mr. KAHN. Those are their actual names, Senator.

Senator DODD. All right. That is nice. That may be the only honest part of this thing. [Laughter.]

This is Louise, now: "The Government picks the health plans. Then we have to pick a plan from their list. That is the choice we get. Well, what if we do not like their choices, what if it is not on their list? There has got to be a better way."

Well look, we are talking about a choice between private plans here. I find it incredible that on that particular point, that the part of the insurance industry represented by your association would object to a notion that actually guarantees that the private sector will be participants in all of this. I mean, today, if you work for a private company, you are lucky to get two choices. Normally, it is one. You work for a place, and they offer one the plan; if you do not like it, find another job.

Isn't that true, basically? Basically, isn't that true today?

Mr. KAHN. Yes, sir, today.

Senator DODD. Yes. And if you are self-employed, you go out into the marketplace, and it costs you a fortune. Isn't that true for what it would cost an individual?

Mr. KAHN. It depends on the plan, but there are products available for people.

Senator DODD. It is very expensive for an individual to go out and buy his own plan. Isn't that true?

Mr. KAHN. Expense is relative, but yes, frequently, it is. I would agree with that.

Senator DODD. Well, my point is that that there is not a lot of choice for people today. That is not a lot of choice. What we are trying to do with this is to give people some choices.

Now, again, you can argue about how successfully a proposal does it, but if you wonder why you hear the outrage from people like Senator Metzenbaum, and my colleague from Minnesota and others, it is because of that, because you leave this impression out there that just is not fair.

Go after the caps. That is a good point, I think, about costs and whether or not you can keep them down. That is a legitimate point. How bureaucratic are the alliances going to be; that is a legitimate point, if you want to raise that. There is significant and honest debate about that. But do not characterize what is out here as lacking the ability for consumers to make choices; or, in the second case, that there is no alternative or no thought being given—God forbid something happens, and you run out of resources—where do you turn to, and how do you deal with that problem?

That is where you get yourself into trouble, and that is why the insurance suffers, in my view, because you take on the wrong issues, and you end up appearing as though you do not give a damn at all about these issues. That is the impression you are leaving.

That is the impression you leave, unfortunately. I have got to tell you that. It is not just Senator Metzenbaum or a few others up here. That is what most people think. That is what folks think in Connecticut where a good many companies call home.

So I would urge you to consider this—keep your ads on if you want, but keep it focused on the legitimate debate, and do not scare people unnecessarily. It is not in your interest; it is not the interest of trying to do something about a serious problem that deserves serious debate and serious facts. And you are not doing that with your present plan of advertising.

Thank you, Mr. Chairman.

You can respond if you wish.

Mr. KAHN. Senator, I appreciate your concerns. Let me first say that I think a number of our members—we have 270 recognizable household names, Prudential, Mass Mutual, John Hancock, The Principal, New York Life, Phoenix from Connecticut; so we have many companies of very high integrity, and many of them have gotten together and decided this was the way they wanted to deal with the issue.

Let me answer the two questions. First, I think the dialogue here with Senator Gregg points out the issue of is there going to be enough money, and I think that discussion at least justifies the ad. And on the choice ads, I think we need to look at the timing of those ads. We ran those in September and then for a couple of days in October, and if you look at the President's plan, it did change between the book that Senator Gregg raised and the bill itself. They changed in terms of the health alliances' ability to limit the number of plans and limit the fee-for-service plans, and they also changed in terms of requiring plans that are closed plans to at least offer individuals the opportunity to opt out and get fee-for-service care from doctors who are not part of the plan.

So I guess what we are confused about is that maybe the administration ought to be giving us some credit, because on the choice issue—and we are not running any choice ads right now—they recognized problems with this plan, and they changed it in the bill. Now, I am not saying we are sold on the health alliances, but clearly our ads and the other concern raised in the community generally had some effect on their legislation.

So I appreciate your concern about the ads. It is not our intent by any means to raise fear with anyone. We think, and the companies I have mentioned think, that we are just raising legitimate issues. And if you take this example of the choice, clearly people in the administration felt so, too, because they changed their proposal from the time that this was released and the time the bill came out.

Ms. MCGIFFERT. I would just like to add that I think it is highly questionable that HIAA is totally responsible for the changes of expanding choice in the President's plan. I know that consumers all across this Nation have repeatedly and consistently, when they are polled, talked about choice being a very, very important point for them. And I think they are communicating those concerns with all of you and with the President.

So I would just question whether HIAA was responsible for that.

Senator DODD. Let me just add that Mrs. Clinton and the President, from the get-go, have talked about choice and the importance of it, and quality and responsibility and a variety of other issues here, with all due respect. But the clear impression overall, which I am just sharing with you—and I am not your enemy here—

Mr. KAHN. No. I am sensitive to what you are saying, Senator.

Senator DODD [continuing]. I am telling you right now that you guys are looking for a lot of trouble unnecessarily, in my view, because I think the ads are deceptive about what they say about where the insurance is on these questions.

Senator DURENBERGER. Mr. Chairman, how much time are we going to devote to each of these? We have another panel coming up.

The CHAIRMAN. I agree. We are trying to move this along.

The Senator from Minnesota is recognized.

Senator WELLSTONE. I will stay within 5 minutes, and I will be the moderating voice here.

The CHAIRMAN. Just a minute.

Senator WELLSTONE. Oh, I am sorry. You are next, Senator Durenberger. I defer. I apologize. Senator Durenberger, I will follow you.

The CHAIRMAN. Can't you guys agree on anything? [Laughter.]

Senator Durenberger.

Senator DURENBERGER. We are agreed on one thing. If I try to raise the other side of the issue because Chip Kahn used to work for me, I am going to get blasted by somebody. And if I defend the insurance industry, I am going to get blasted because they contribute to my campaign, and I do not know what light we are shedding on the whole issue.

I appreciate how much time my colleagues have spent on trying to influence television advertising, but I think to some degree what we are missing out on here is how are we going to get to the American people about the nature of this problem.

I remember back in May saying to the President at a lunch: "You are going to come up with a plan, and it is going to be the best of all the 500 plans, but if you have not spent time in conversation with the American public about the nature of the problem and how to deal with it, we are going to have problems."

So whether it is HIAA or the administration with their DNC money, or whomever it is—everybody is selling some version of a plan or something they do not like about a particular plan, and we really are not dealing as we should, and as most Americans and most Minnesotans would like us to deal, with the nature of the problem.

Let me give you one example. I believe—and I should have asked him to repeat it—but I thought I heard the chairman at the beginning, gesturing to those charts, talking about the uninsured, saying that every month in Massachusetts, there are 50,000 more. Is that correct?

The CHAIRMAN. That is right. Fifty thousand lose it every month.

Senator DURENBERGER. OK. Well, the implication against that chart, Mr. Chairman—and I just need to clarify this for everybody—\$50,000 a month times 12 months is 600,000 folks a year. I do not know if Massachusetts is typical of the rest of the country,

but the average loss between 1988 and 1989 was 800,000; between 1989 and 1990 was 1.3 million.

I raise this because technically, you are saying so many people lost, but you are not explaining that somebody got it back before the end of the year.

Senator DODD. Well, that is true. We lose 23,000 a month in Connecticut, but many of them before the year is out get back on. But God help you if you end up with a problem in that week or two you are off.

Senator DURENBERGER. Exactly. All I am saying is let us be clear what we are talking about.

The CHAIRMAN. Well, I thought I said 50,000. There are 700,000 who do not have coverage at a particular point in time, and there are 50,000 who lose their coverage each month. Now, those are not inconsistent, for the reasons we have outlined here. And I can give you the Families U.S.A. and the Lewin reports; that is completely consistent with the studies that have been done in Atlanta.

Senator DURENBERGER. Mr. Chairman, the point I am making is that every time the President is talking about the uninsured in America, and he says 200,000 more people are added to the rolls, or something like that, every month; and you said 50,000. And the way people think, that is a cumulative number. The reality is, it is not. Let me make that point.

The second point I would like to make is with regard to the nature of the reform that is proposed. I went through with the witness from Consumers Union—and let me just go through your statement—everything that I saw in your statement that you support here in terms of insurance reform, I did in 1991. I give credit to Kathy Means, who was the person who worked for me then and works for HCFA now; she put the bill together. Last year, we passed it twice, out of the Finance Committee and passed it on the floor of the Senate by 97-0 votes.

We raised insurance regulation to the national level, health insurance, rather than the State. We got rid of cherry-picking, cream-skimming, discriminatory practices, limited the underwriting margins, eliminated pre-existing conditions as a way to experience rate plans, added guaranteed issue renewal, portability, built on the COBRA efforts that Senator Kennedy and I did in 1986. We came up with a comprehensive benefit package. You have to have a benefit package, or you cannot do underwriting reform. That is where all this begins.

So a lot of what Americans really want is to get the price for this product, that we agree is too high, approximately the same for the same benefit package in the same community, and we have a consensus on what we are talking about for insurance reform.

The next step we seem to be taking is converting the traditional insurance system, of which you are appropriately critical, to an accountable health plan. And I wonder if you couldn't just take 30 seconds or so and describe for the committee something that is never talked about in our debate, and that is what is an accountable health plan; what are the rules that are contained in the Clinton plan for an accountable health plan; what are these national rules under which this new form of insurers are actually going to operate?

Ms. MCGIFFERT. Well, it is my understanding that the rules are setting what the package is going to be. The rules will require the plans to meet certain conditions before they are eligible to be certified by the alliance or by the State to be available to people, so that there are some assurances with an oversight to consumers as to what they are getting, and there is going to be some consistency so consumers can make some comparisons. There are also restrictions on plans dropping people, and restrictions on people being cut out of the plans.

So that will certainly be some progress for consumers in that they will not be excluded.

Senator DURENBERGER. Well, obviously, you have spent a lot of time dealing with insurance. Please describe for us this new vehicle, the accountable health plan. How does it differ from the old indemnity insurance, and why is it important to have national rules for this health plan rather than the State by State rules? And what impact is that going to have on consumers? How are consumers going to be able to be more involved through accountable health plans in making choices than they were before? Help us understand that, because not very many people have been able to do that so far.

Ms. MCGIFFERT. Well, because of the uniformity in the plans, it is going to make it easier for them to compare plans. I think that the State by State regulation is such a patchwork. One State may be very successful at regulating insurance plans, and possibly Minnesota is one of those; Texas is not. We have very little regulation and very little protection. So that a person who lives in Texas does not have the same guarantees with regard to access to health care as someone in Minnesota, and that is a problem. We live in a mobile society, and we move from State to State, and it is real important, in our opinion, for us to have a national system and for us to recognize that health care is a necessity for all the people in this country, just as other countries have recognized.

Senator DURENBERGER. Mr. Chairman, I have used up my time, but I think this is a point we ought to expand on some other time.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

I was going to say to you, Mr. Kahn, just think of service you could render to this country—you could design ads that were 100 percent accurate and that informed people, did not appeal to fear, and then you could set a model for people running for office.

The second point. On the question of—and I think the chairman may have asked this question of you—how much of the health premium per se of companies you represent are going into the advertising and lobbying expenses? I did not say life insurance. I want you to separate that out for us.

Did you ask that question, Mr. Chairman, while I was out of the room?

The CHAIRMAN. Yes.

Mr. KAHN. He did not ask that precisely, and I do not have an answer for you. I will be happy to look into it and see what I can get. As I said, our companies are large companies that have multiple products, and I cannot give you a specific answer. It is not something we have asked of them when they have contributed.

Senator WELLSTONE. You said you would be able to get that information?

Mr. KAHN. I will do my best. All I can say is I can go back to the companies and make a request if you have asked for it.

Senator WELLSTONE. I think that would be very helpful.

Ms. McGiffert, did you want to comment?

Ms. MCGIFFERT. Well, I just wanted to say that it is very true that consumers also do not know how much of their premium dollars that they give to private insurance is being spent on marketing and advertising and promoting their own interests.

Senator WELLSTONE. Exactly, and that is why I asked it. By the way, the comment I made earlier, maybe the mood piece of that was not understood. I actually very much agree with what my colleagues were saying. It is just that I think all of us, Democrats and Republicans alike, would love to see this whole issue of capital-intensive TV campaigns, whether it be in health care or whether it be in relationship to politics, something done about the ways in which they certainly do not inform people, but quite often do the opposite. That is the reason why I made that point.

I would very much like to get that information.

The third point. Senator Durenberger was talking about the State of Minnesota—and this is not meant to open up a big debate between the two of us; we have different perspectives, and I think we have had a relationship of mutual respect as we develop those different perspectives and speak about them—but just to give you an example of one of the things that I think really angers people, and this has to do with one of the networks. Dick Youngblood, who is a well-known business columnist, wrote a piece in the Star Tribune. The CEO of United Health Care Corporation in Minnesota last year, salary and stock options, \$8 million; this year, \$12 million. That is one of the big managed care networks.

I just have to tell you that this is one of the reasons why people become very wary of where all of this is heading. The critique of people that, for example, talk about single-payer insurance agency is not personal at all, Mr. Kahn. It is not a question that all companies are bad. I do not believe that for a moment. It is more systemic, and I think there are two issues. One of them—and I take it there is consensus that this will be corrected—is that with the insurance industry, the bitter irony for consumers is that you have to prove to the industry that you will never use health insurance in order to be able to obtain it. That is one of the reasons why people have been so angry at the health insurance industry—that is to say, all sorts of people who either cannot obtain coverage or afford it because of prior or current health care conditions.

The other issue is one of administrative bloat and excess profiteering. I think the one question I would ask you is your organization represents some of the smaller insurance companies. Now, from Ms. Nichols, we heard testimony as to the trend of some of the larger companies coming in and buying up a lot of these managed care networks. Do you have concerns—I have 1 minute left—about some of the larger health insurance networks buying up some of the smaller companies that you represent?

Senator DURENBERGER. Mr. Kahn, if you would yield to me on your time, I need to just clarify and not necessarily respond—and

Paul has accurately characterized our relationship—most of the time.

Nobody can defend \$12 million, \$7 million, or \$133,800 salaries for 535 people who theoretically all do the same thing but have different approaches in going about doing it—and that is not my purpose.

Let me second agree with him that a lot of people, including doctors, who think about single payers in Minnesota, think maybe that is a good idea when they see that so much money is going into advertising or whatever the case may be. And with relatively focused publicity, that does happen.

But let me also say that in the year that Mr. McGuire got his \$7 million, what his company did was double the stockholders' equity in that company, meaning they made a lot of money for the company, so to speak, but the net effect of making a lot of money for the company or the owners of the company was they did it by reducing the cost of the product that they were selling in the marketplace and expanding the number of products that got sold.

Now, what does that tell you? That the company is greedy, or something like that? No. It says that there is so much in this system by which costs can be reduced that there is somebody out there who under the current system can make that much money by doing things differently.

Second, quality. Everybody talks about report cards. Where did report cards begin—the information medium by which you can determine what you are getting from your plan. It began with United Health Care, sort of an invention that everybody is now touting as a way in which we as consumers can learn more about what is going on.

How much is that contribution to American health care and consumers worth? Twelve million? Seven million? Two million? One and a half million? I suspect it is probably going to be worth billions, because everybody wants to do it now because it is a way to get inappropriate care out of the system.

So Mr. Chairman, I need to add that dimension, whether anybody listens or not, because it is much easier to talk about \$12 million or \$7 million; it is much harder to explain the value in a report card in outcomes-based information in a new kind of a product that actually helps consumers be better buyers of health care.

Senator WELLSTONE. Well, first, I appreciate that.

Senator DURENBERGER. I am sorry it took so long.

Senator WELLSTONE. I understand, and the other perspective on that, of course, is that we do not see much of a correlation—and I could argue the Minnesota case with you as well, Senator Durenberger—between the high salaries—I did not ask Mr. Kahn exactly for information on the CEO salaries of the different companies he represents—but people so far in this country have not seen much of a correlation between that and cost savings for the citizens and the consumers. And therefore people have a very healthy skepticism about the role of the insurance industry in the financing and delivery of health care, as they well should.

My question—I just had that one question as to whether you are concerned about this trend for some of your smaller companies.

Mr. KAHN. Well, let me say two things, Senator. First, our companies on average make under 2 cents on the dollar of premium in profit. But second, we have a range of companies in HIAA, from The Prudential down to very small firms. I do not know what that mix of companies is going to look like 5 years from now, and in some ways, that is not the association's problem; it is the companies' problem in the marketplace. What we are concerned about is a reform being done that will give those companies the opportunity, the day the law is enacted, to offer a product in the marketplace that they think will meet the needs of consumers. If they cannot—and that will include plans that can assure they can lower costs and still meet the quality needs—then they are not going to make it.

We just want to make sure they are there and have the opportunity and that the law does not put them out of business because of the way the law is passed.

Senator WELLSTONE. And just to bring this to a close, I thank you very much, and if you could provide me with—I think this is something that many of us would be very interested in—if you could provide me with information as to what percentage of the health insurance premium that people are paying to companies you represent goes directly into your advertising and lobbying—you said you would be willing to try to get that.

Mr. KAHN. I will make an attempt, Senator.

Senator WELLSTONE. I think consumers would like to know that. And the other thing I would be interested to obtain from you would be the CEO salaries, including stock options from the companies that you represent.

Mr. KAHN. Whatever is public information. I will have to look into it. I will do my best.

Senator WELLSTONE. I appreciate it very much—and the dollar amount.

Mr. KAHN. I will do the best I can.

Senator WELLSTONE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. We appreciate it.

Our final panel includes Mary Nell Lehnhard, senior vice president of Blue Cross and Blue Shield; William Mauk, Jr., chief executive, Healthcare Management Division of John Alden Life Insurance Company in Miami, FL; Robert Tedoldi, Benefit Plans Design Administration, and president of The National Association of Life Underwriters, Vernon, CT; and Alan Katz, Centerstone Insurance and Financial Services, and legislative chairman of the National Association of Health Underwriters.

As we indicated at the outset, we are unfortunately in a time squeeze, so we would ask each of you if you could follow a 4-minute rule, and then we will submit questions to you in writing. We apologize at the outset.

Senator JEFFORDS. Mr. Chairman, I want to assure the panel that I will have questions for them. It is unfortunate we are running out of time, as I would have wished we could do that here today. But I appreciate your being here, and we will have written questions for you.

Thank you.

The CHAIRMAN. Thank you.

Ms. Lehnhard, if you would be good enough to begin.

STATEMENTS OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC; WILLIAM H. MAUK, JR., CHIEF EXECUTIVE, HEALTHCARE MANAGEMENT DIVISION, JOHN ALDEN LIFE INSURANCE CO., MIAMI, FL; ROBERT L. TEDOLDI, BENEFIT PLANS DESIGN ADMINISTRATION, INC., AND PRESIDENT, THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, VERNON, CT; AND ALAN KATZ, CENTERSTONE INSURANCE AND FINANCIAL SERVICES, AND LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, SANTA MONICA, CA

Ms. LEHNHARD. Mr. Chairman, I will keep my remarks brief.

I am here representing the 69 independent local Blue Cross and Blue Shield plans. We represent over 60 million people as subscribers, and one-third of our enrollment is in managed care networks. And I would say the most important thing that I could leave with you today is that we want to see a health care reform bill enacted in 1994.

We strongly support the President's objectives of health care coverage for everyone, strict Federal standards for insurance companies, and cost containment through managed care networks.

We think insurance reform is the first and most important step. These are all to be taken together, but we think insurance reform is really a key issue. Insurance companies must be told they cannot refuse to accept anyone, they cannot drop people, and they have to charge a fair rate. And self-funded plans have to play by the same rules. We think this is really the heart of the security issue for most Americans.

But insurance reform is more than that. It is also the foundation for an effective cost containment strategy. And right now, as you have heard this morning, insurance companies are competing on the ability to select healthy people and keep their premiums low.

Four percent of any population will generate 50 percent of the claims cost, so many insurance companies are investing in how to avoid that 4 percent and keep the premiums low that way. If these risk selection practices are stopped, insurance companies will focus all of their energies and all of their investments on truly managing costs, and that is the first step to true cost containment.

These incentives combined with incentives for consumers to choose more cost-effective health plans offer the best way to make a fundamental change in the way we use services. We need to make it possible for the first time for consumers to buy insurance like they buy other products, evaluating quality, shopping for the best price, standardizing the benefit package so they can compare, requiring health plans to report standardized data on quality of care, and revising the tax code to promote cost-conscious decisions when they purchase their health plans.

Finally, every American should have coverage. We believe the fairest way to do that is requiring the employer to contribute to the benefit package and requiring individuals to purchase the rest of it.

Unfortunately, under the President's proposal, none of these reforms start until the States have their mandatory health alliances up and running. We think that making reform totally dependent on having alliances up and running will not only delay reform; it could jeopardize it.

We know from first hand; in the Federal employees program, we have over 4 million subscribers on an individual choice. The tasks that they are asking these alliances to do are extraordinarily complex. Managing the premium collection for millions of individuals and managing an annual open enrollment for millions of people switching coverage at the same time is an awesome task. And importantly, these alliances are not needed to achieve universal coverage, insurance reform, or cost containment. And let me give you just a couple of quick examples.

The administration has said that alliances are needed to pool purchasing power. Even under their proposal, the purchasing power of the market does not come through the alliance; it is done through the community rate requirement on the health insurance companies. So if you take away the alliance, you still have a major pool of claims experience, and everybody gets the same rate.

Another way to say this is that the health plan has to offer their best rate to everyone in the market because they have to sell to everyone at the same price. You do not need an alliance to do this. It is the community rating requirement that gets you there.

We also think that mandatory alliances are not needed to reduce administrative costs; in fact, they may add to them. And we have suggestions in our testimony for how to reduced the administrative costs, including eliminating paperwork for consumers and standardized forms for providers.

A quick comment on Senator Kassebaum's concern this morning that voluntary alliances, which we support, will fragment the risk pool. We think it is very important that they do not fragment the risk pool, and we believe the way you avoid this is to say to a health plan: You have a community rate. You use your community rate regardless of the distribution system, whether you sell directly to the employer or whether you sell through Alliance A, Alliance B, or Alliance C. This means that you have the same number of health plans under a voluntary alliance system as you would have under a mandatory alliance system, and again, that what you need to offer large employers and small employers, that pooling of risk, is not fragmented by a voluntary alliance coming in and peeling off the best risks and setting up a new pool of experience.

I will stop there and stand ready for questions.

Senator JEFFORDS [presiding]. Thank you. Just a comment. I think you would agree—and this is basically a comment to all of you—Senator Durenberger pointed out the insurance reform provisions. Vermont has done that, and we have found, though, that we still do not by any means have universal coverage. It has cut in half, probably, the number of people not covered, but it certainly has not given us universal coverage.

Ms. LEHNHARD. And we support the President's proposal for universal coverage.

Senator JEFFORDS. OK.

[The prepared statement of Ms. Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify on the Health Security Act of 1993.

INSURANCE REFORM: THE FOUNDATION OF HEALTH REFORM

There is a consensus across this nation and in Congress that insurance reform is one of the central elements in comprehensive health care reform. Fundamental changes in the basic rules within which insurers operate is a key component of the major health care reform proposals.

As Congress begins the debate on health care reform legislation, I cannot over-emphasize the significant impact of insurance reform on carrier practices. The types of insurance reforms that I will discuss would move the market away from competition based on risk selection. Risk selection is the reason we do not have true price competition in health care. It is easier for many insurers and Health Maintenance Organizations (HMOs) to hold down costs by screening out high risks than by managing overall health care costs. A clear illustration of this point is that 4 percent of any population will generate about 50 percent of all the claims costs. Many insurers, if they have the choice, will invest in techniques to avoid those high risks rather than invest in techniques to manage cost.

Insurance reform eliminates risk selection as a tool for maintaining competitive prices. Instead, insurers would have to compete on the basis of their ability to manage costs.

We believe that strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market—and assuring fairness to consumers. Federal standards defining a health plan should:

1. Require insurers to accept everyone regardless of their health status or employment;
2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;
3. Prohibit insurers from dropping people or groups when someone gets sick and require insurers to offer continued coverage when a person loses his or her job;
4. Require insurers to set premiums fairly and not penalize people who are sick or older; and,
5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and HMOs. Self-funded plans must play by the same rules and be held to the same standards as health plans.

INSURANCE REFORM BY ITSELF IS NOT ENOUGH

While new rules for insurers are an essential part of health care reform, by themselves they will not be sufficient to contain costs and achieve universal coverage.

Cost controls: New standards for the way insurers do business can be an underpinning of a successful cost containment strategy. In addition, insurance reform will allow individuals, employers and employees to weigh both price and quality when purchasing coverage by requiring:

1. Standardization of health benefit designs. While we do not believe a single standardized benefit design will be workable, a limited number of standardized benefit designs will allow consumers to easily compare products.
2. Health plans to report standardized data on quality of care and subscriber satisfaction.
3. A limit on the tax deductibility of employer contributions for health benefits to an amount consistent with cost-efficient health plans.

These features will encourage the expansion of organized delivery systems that have a proven ability to change inefficient and ineffective utilization patterns and cause providers to become more efficient providers of health care.

Universal coverage: Making more affordable insurance available would reduce the number of people without insurance benefits, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, would be necessary to achieve universal coverage.

Such a requirement, however, would impose a severe burden on many small employers. To make it possible for small employers to comply with the mandate, subsidies would be needed. These subsidies should be targeted to companies that rely heavily on low-wage workers.

NEED TO INCREASE COMPETITION AND MAINTAIN STABILITY

Two elements of the Clinton Administration's recent proposal cause us concern. These include the proposal's reliance on large regulatory health alliances to perform an extraordinarily broad and complex range of functions, including compliance with the new standards of market conduct, and the proposal's reliance on global budgets and premium caps to control costs. We do not believe either large alliances or premium caps are necessary to achieve the goals of universal coverage and cost containment. Instead, we are concerned that both may lessen the effectiveness of the new rules governing the insurance market.

Large regulatory alliances: Under the Clinton proposal, all individuals and families in firms with less than 5,000 employees would enroll in a health plan through a regional alliance. Individuals would enroll in the regional alliance in the area in which they reside. There would be one alliance per geographic area, and the alliance would contract with all state-certified health plans. Each individual would enroll in a health plan through the alliance as an individual; employers would have no role in selecting coverage or overseeing the health plans used by their employees.

We do not believe that mandatory health alliances—large or small—are necessary to achieve the goals of cost containment or universal coverage. All but one of the functions envisioned for the health alliances are, or could be, accomplished through strict federal standards for insurance reform combined with stronger incentives for employers and individuals to purchase cost-effective health plans—without adding a new administrative layer.

States, not alliances, would assure that all individuals and small employers have access to coverage by requiring all health plans to: accept all applicants regardless of their medical or employment status; not drop an individual or a group because of medical problems; and set premiums in a way that does not penalize older or sicker workers.

States would require health plans to set rates for large community-rated pools so that individuals and small groups have the same ability to pool high-risk and low-risk individuals as large employers. Even under an alliance structure, the "pooling" takes place at the health plan not in the alliance.

Requirements for administrative simplification would reduce administrative costs by standardizing benefits, reducing market costs, eliminating paperwork for consumers and standardizing forms for providers. Large, mandatory alliances would increase administrative costs by: 1) moving several thousand employer transactions to millions of individual transactions and 2) duplicating functions of health plans that must continue.

An alliance is not needed to negotiate with health plans on behalf of individuals and small groups. If health plans were required to charge the same rates for all individual and small group enrollment, all health plans would have an incentive to drive the best bargain for everyone. Limiting the amount of tax-free coverage that employers and consumers can purchase to the cost of an efficient plan, and giving employers and consumers the information they need to select a health plan based on price, performance and service levels would cause health plans to compete vigorously on price.

Risk adjustment to account for some health plans enrolling a disproportionate share of older or sicker individuals could be accomplished just as easily outside an alliance through an independent agency operating under the supervision of the state insurance commissioner.

An alliance is not needed to offer individuals an expanded choice of health plans. The choices available to individuals can be expanded in a number of ways without creating a large, mandatory alliance. Large employers today often offer several different types of health plan options for the employee and could be required to do so. Small employers could offer similar options or could participate in a voluntary alliance to allow their employees to choose from a "menu" of health plans.

An alliance would be necessary to administer indirect subsidies. Such indirect subsidies would result from: Allowing states to purchase coverage for Medicaid recipients at 95 percent of what the state is currently paying for Medicaid benefits. Many states currently pay providers at rates that are below prices established in the more competitive private market. If state payment rates are, for example, even 75 percent of those prevailing in the private sector, then the cost

of providing the guaranteed benefits package for Medicaid recipients could exceed the state's premium payment by more than 40 percent; Individuals or employers who fail to pay premiums would continue to receive coverage (health plans are prohibited from dropping individuals for nonpayment), and their bad debts would be spread across all other employers and individuals through an assessment on premiums; Premium payments by employers for part-time workers may fall short of the employer's share of the premium, requiring full-time workers to pay more for coverage.

However, we believe these costs should be subsidized directly rather than "hiding" them in a complex alliance structure.

Premium Caps and Global Budgets: Global or alliance budgets administered through premium caps promise less spending, but we believe they would prove to be ineffective and would preclude a smooth transition into a more competitive and efficient system.

1. Premium caps would be driven by federal budget priorities and politics that have little or nothing to do with health care. One decision in Washington would determine the amount of money available to provide needed health care in each health alliance area.

2. By relying on a process that is not a reliable predictor of how fast communities should be expected to eliminate inefficiencies, premium caps would force the rapid downsizing of provider networks, reduced availability of sophisticated diagnostic and treatment technology, increased waiting times for consumers, and a decline in customer service. Plans that cannot comply with the limits would either be forced from the market—or forced into insolvency. The end result would be fewer choices for consumers.

3. Premium caps would limit the innovation needed to truly change behavior, by limiting the ability of health plans to invest in ways of better managing practice patterns and achieving better outcomes for their members.

4. In the absence of proven methods of risk adjustment, health plans could exceed their premium cap because they have enrolled higher-risk subscribers not because they do not effectively manage costs.

Although some argue that premium caps are needed to enforce limits on spending, we believe that the new rules for health insurers will lead to vigorous price competition that will be more effective in controlling costs over the long run and support a more orderly transition into a reformed health care system.

CONCLUSION

I would like to reiterate our strong belief that insurance reform is the key to containing costs and assuring access to coverage. Reforms are needed to make coverage available for employers that have an employee who has a serious medical condition, reduce the wide variation in premiums charged to groups based on their health status, limit increases in premiums for small employers that result when an employee develops a serious medical problem, and assure coverage for individuals with existing medical conditions.

Federal policies to give employers and individuals a greater incentive to select cost-efficient health plans that deliver high quality care, and to enable them to compare the options that are available in a reformed market will complement insurance market reform. The benefits of reform can be realized without resorting to either premium caps or large health alliances that could actually work against the objectives of reform.

Senator JEFFORDS. Our next witness is William Mauk, Jr., chief executive, Healthcare Management Division of the John Alden Life Insurance Company of Miami, FL. Welcome.

Mr. MAUK. Thank you.

My name is Bill Mauk, and I am an individual who is concerned with the condition of our health care delivery system. I am a Group Health Insurance executive who is here to help, and I am also a board member of the Agency for Health Care Administration, which is involved in the development and implementation of Florida's comprehensive health care reform, and I have been holding hearings around the State of Florida, having the public come forward and providing their views on their concerns about the health

care system, the Chiles plan in Florida, the Clinton plan, and the role of regulation.

I am also the chair of the South Florida Health Planning Council, which provides comprehensive health planning as a not-for-profit organization in Dade County. And unfortunately, I am from Dade County, which has the highest cost of health care of anywhere in the United States.

So I am here to help. I have had some experience, and I want to assist you in your decisionmaking.

The financing and health care system of our country is flawed; some would say that it is broken. It is in disequilibrium, and it will not self-correct unless we intervene.

Many millions of Americans have inadequate health care; others are locked in their jobs or on welfare because they may lose it if they change. Many are paying more than they should because others are not responsible.

On the other hand, by far, most Americans are satisfied with their plan. Our system can deliver care that is the best in the world.

On the other hand, the health status of America is below average compared to other industrialized nations, and we spend more of our gross domestic product than any other industrialized country on those services.

While there are reasons for this that are beyond the health care system, such as have been mentioned this morning—crime and poverty—we need to aggressively address the problems of our health care system.

Our social fabric is being weakened because we have not solved our problems in health care.

There are many things that we agree on, particularly insurance market reform, guarantee issue, community rating, portability of coverage, renewability of coverage and guaranteeing that, pre-existing condition limitations, and many more; administrative savings—we need them. There are many things that we all agree on and how they can be accomplished. Malpractice reform. Quality assurance. Outcome information. Information to the public on how different integrated delivery systems are performing and on choice. Everyone should have a fair choice in terms of what alternative they have to have health care delivered to them.

There are things, however, that we do not seem to have much agreement on, and they include how we finance this, how we achieve savings, and whether we should have a mandate for coverage, and even if we do think there should be a mandate, whether it should be on employers and employees or just on employees themselves or individuals.

It seems to me that we need a mandate that is a fundamental, nonnegotiable point in terms of how we should get health care going in terms of its reform. Everybody needs to be in the system. We cannot allow for people not to be in the system. Everyone needs to be responsible.

However, if we do that, we also have an obligation if we require people to be in the system to assure them of some predictability in terms of what they are going to be paying. I believe the President's

plan provides this. I think it is a good experiment in terms of Federal, State and private partnerships.

I think, though, that the critical issue here is that we do need to allow experimentation on a State by State basis. We are dealing with one-seventh of our economy. We do not have all the answers. No proposal is without serious and legitimate criticism. We need time for change. We need to experiment with what alternatives work. There are going to be new relationships that are developed between insurance companies, providers, between AHPs and alliances. We need time for those things to develop. We have to increase the capacity in certain aspects of our delivery system, such as primary care. And really, many things that we need in order to have this work, we do not yet know.

Risk adjustments, yes, that is a good concept; we have not done much of it. Integrated systems of easily processing claims, we are working on that, but we have not developed a full system. And you can go on and on—outcomes, practice parameters. We need time and we need investment in order to do those things.

I think that the President has framed the debate. I support his efforts, and I think that his proposal is the best one that we have in front of us.

Senator JEFFORDS. Thank you very much.

[The prepared statement of Mr. Mauk follows:]

PREPARED STATEMENT OF BILL MAUK

Mr. Chairman and members of the Committee, my name is Bill Mauk and I am the Chief Executive of the John Alden Healthcare Management Division of the John Alden Life Insurance Company. I am pleased to testify today in support of President Clinton's plan to reform our health care system. My values lead me to believe that access to health care in the United States is a right. We must no longer tolerate the inequities and unfairness in our system. Our health care delivery system has tremendous capacity to provide high quality health care. We must change our system to assure that it does provide such care to all Americans.

I believe President Clinton has proposed a solution to a large and complex problem. His proposal is in the best of the American tradition of using federal-state-private partnerships which allow for experimentation within a unified framework. I strongly support using market forces to change the way health care is delivered. Yet, I believe we must do more to ensure that all Americans have affordable health insurance with universal access. Our current financing and delivery system is in disequilibrium. Market forces alone will not correct the problem.

Every proposal engenders serious and legitimate criticism. I recognize that changing our health care system will be difficult as we are working with one seventh of the nation's gross domestic product. I am here today to put my support behind the President's objectives and plan.

John Alden Healthcare Management

John Alden Healthcare Management is uniquely qualified to comment today on the role of insurers in our health care system. We are principally engaged in providing group life and health insurance to smaller businesses. We are one of the largest providers of group insurance to small employers, covering over 170,000 employers and 1,000,000 insureds. The average size of the employers we insure is slightly over 3 workers. We also provide administration, benefits consulting and reinsurance to large self-insured employers. John Alden has been providing group health insurance to small employers since 1969.

During the past several years, we have seen many insurers pull out of the small business market. Serving our customers has required us to continually adapt to the changing needs of the marketplace. For more than 20 years, we have designed products to help employers manage their health care costs. We offer employers a variety of coverage options to reduce claim costs, lower premiums and improve the efficiency of care for their employees and dependents. Our emphasis is on managed care programs that reward employees for their efforts to control medical costs. John Alden's comprehensive programs include utilization review prior to hospital admission, case

management programs for complex medical treatment and catastrophic illnesses, and using Preferred Provider Organizations (PPOs) to offer access to an array of physicians and hospitals that provide medical services at pre-negotiated savings.

One major challenge facing our health care system is to provide doctors, hospitals and patients with incentives to be more conscious of health care costs. We currently assist employers in identifying less expensive providers through our PPO managed care network. John Alden is continually negotiating with providers to expand our network which currently includes over 3,000 hospitals and 100,000 physicians. We provide for complex patient care using "Centers of Excellence" such as the Mayo Clinic.

HEALTH CARE REFORM

After having been an observer and participant in our health care system, I would make the following observations:

The small employer insurance market has suffered from certain insurer practices. Such practices include: medical underwriting, reentry underwriting, substandard pooling, experience rating small businesses, and cancellation due to bad claims experience. These industry practices have prompted the need to change the rules of the insurance market.

Most small business employers want to offer health insurance to their employees, however they face significant administrative costs, high premiums, preexisting condition clauses, and exclusions from coverage and/or participation.

In many instances, current health coverage is not portable from employer to employer.

Individuals with preexisting conditions do not have affordable access to health care.

SUPPORT FOR THE CLINTON HEALTH CARE PLAN

I strongly endorse the principles set forth by President Clinton: security, simplicity, savings, quality, choice, and responsibility. President Clinton's plan is the most thorough and comprehensive approach to achieving these important goals. A restructuring of the way in which health care is financed and delivered is necessary to ensure all Americans have coverage. Specifically, regulatory cost containment features must be available to ensure that the new market forces created by President Clinton's proposal will slow the rate of growth in health care expenditures. I believe the outcome will be a more affordable health care system.

SPECIFIC AREAS OF REFORM

I have been asked to comment on particular features included in the President's proposal: premium caps, the structure and size of the health alliances, and consumer choice.

Premium Caps

It is important to limit increases in health care costs. If market forces alone do not produce the necessary reductions, we need regulatory alternatives. A regulatory structure which limits increases tells every American that the overall cost of the proposed system is both fair and predictable. Moreover, if health plans know what allowable rates of increase are, it will assist the health plans in their provider negotiations. Those health plans who can further contain increases will most likely be more successful.

The fundamental rationale behind premium caps is that they permit us to achieve firm cost containment beyond simple reliance on market reform. Premium caps avoid resorting to micromanagement or service-by-service price controls. Premium caps serve as a "hands off" way of containing costs, while leaving the day to day management of costs to health professionals, as opposed to government dictated price controls.

We must have firm cost containment alternatives that send a signal to the market that discipline will be imposed if market forces do not adequately limit health care cost increases. I know that several members of this Committee have worked diligently to develop acceptable mechanisms for such limitations. I applaud Senator Kassebaum's leadership in this area.

Nature of Regional Alliances

Some question various aspects of the structure of the health alliance. I would like to discuss these issues point by point:

Exclusive Health Alliances

The sole public policy reason for health alliances is to marshal economic clout for small and medium sized employers. To be effective, health alliances must be large enough to 1) spread risk; 2) achieve administrative economies of scale; and 3) provide enough membership so that numerous health plans will have enough purchasing power to influence costs and improve quality of health care.

While it might be prudent to evolve into exclusive health alliances, it is my opinion that exclusive health alliances are critical to the success of managed competition. Health plans will need at least 5-10% of the total market to have the bargaining power to influence health care costs and improve quality of health care. I am concerned that if there are multiple competing alliances with multiple health plans, there will be adverse or anti-selection against some of the health plans. While there are theories of risk adjustment mechanisms to address this issue, we do not now have the capability to adequately correct anti-selection problems. Therefore, we need exclusive health alliance with competition occurring among the health plans within the single alliance. Additionally, consumer selection among health plans is best served by using exclusive health alliances.

Mandatory Participation in a Health Alliance

As I indicated above, health alliances must be large enough to effectively marshal economic clout for small and medium sized employers. In addition to being exclusive, I believe health alliances must have mandatory participation to further guard against anti-selection. Mandatory participation is necessary due to the wide variation in health risks and costs among the employees of small and medium sized employers.

The Clinton health plan provides a mechanism to correct for this variation in health risks among those in the alliance. Current risk adjustment mechanisms do not compensate across pools but only within pools and would therefore not prevent this phenomenon. These considerations would argue that the Health Alliance cannot be purely voluntary; it must be mandatory. There have to be powerful incentives to force good risks to join the pool. Voluntary pooling arrangements do little to spread the risks of high medical costs and do little to achieve economies of scale in administration.

Size of the Alliance

The Clinton Administration's proposal would require all companies under 5,000 employees to participate in the health alliances. I am not certain what the ideal number is, however, the bigger the alliance, the better the ability to aggregate costs, spread risks, and negotiate better value for the participants.

Consumer Choice

The Clinton proposal offers employees the choice to select among competing health care plans. In today's market, employers choose the health plan or plans offered to their employees. For the largest employers, employees have some choice among health plans. For the smaller employers, employees usually have no choice. The Clinton plan will increase choice for most Americans.

Individual choice of a plan is important—it maximizes the price elasticity of demand and provides greater incentives for competing plans to reduce costs and increase quality.

In addition, the Clinton plan now requires all health plans offered by the alliance to include a point-of-service option for all enrollees. This requirement will also apply to managed care plans. Therefore, the Clinton health care plan does preserve individuals right to select their own doctor.

Other Reforms

Finally, I support other provisions of President Clinton's Health Security Act which will change the administrative process of health insurance and claims processing. We should use our current technology to get every American a health security card that helps streamline benefit and payment determinations. It is also imperative that we reform our medical liability laws; we provide greater understanding of the antitrust laws; and provide Americans with better consumer information about the price and quality of their health care services. I also support further development of electronic data interchange (EDI), practice parameters, and outcomes analysis.

Closing

In closing, I want to re-emphasize that I am proud to work with a company that did not abandon the offering of health insurance to small employers. John Alden's premium rating and underwriting policies have consistently been in compliance with

new laws mandated by many of these states even before enactment of insurance reforms. We have demonstrated our ability to adapt and we have turned that ability into a competitive advantage. Health care reform is good for industry, good for consumers, and good for America. President Clinton's Health Security Act will bring great change to the health care industry in the way benefits are offered, designed and paid for. This is a change we must be willing to accept. It is up to our industry to address these challenges, not oppose them.

Senator JEFFORDS. Our next witness is Robert Tedoldi, CLU and ChFC, with Benefit Plans Design Administration, Inc., and he is president of the National Association of Life Underwriters in Vernon, CT. Welcome, Robert, and please proceed.

Mr. TEDOLDI. Thank you, Mr. Chairman.

My name is Bob Tedoldi, and I am speaking on behalf of the Association of Health Insurance Agents, and The National Association of Life Underwriters of which I am president.

NALU has 143,000 life and health insurance agents across this Nation. I come to you today not only as an insurance agent with 24 years of experience, but also as an employer of 18 people, 5 of whom spend their full time in the service of 260 health plans, averaging 20 employees, at an average commission of 2 percent.

Also as a small business owner, I pay taxes, meet a payroll, provide benefits, and all the other things an employer has to do.

Let me begin by stating our strong support for health care reform. We support efforts to achieve universal coverage, and we believe that health insurance should be guaranteed issue, guaranteed renewable, portable, and subject to streamlined paperwork and administrative procedures. We agree that there is a crucial need for cost containment, and steps need to be taken to achieve cost control.

We also agree that full, free, and fair competition is the best way to achieve cost control. We also strongly support an active role for the employer in providing health care coverage for all Americans.

Of most concern to us is the issue of exclusive buying groups. Most reform proposals envision creation of some kind of buying group. Buying groups are intended to consolidate the market power of many individuals and employees of small businesses, streamline administrative costs, and eliminate or minimize risk assessment as a basis for issue and/or price of health insurance coverage. We are willing to work with Congress, as we worked with the legislatures in California and Florida, in designing and helping to implement those buying groups.

But we believe that participation in buying groups should be voluntary, as they are in California and Florida, and as it would be under the Chafee bill. Of course, insurance reform rules must be applied to all insurance, whether it is purchased from a buying group or from outside the buying group. This assures a level playing field and eliminates adverse risk selection.

Let me amplify our thoughts on buying groups and why they must be voluntary. Voluntary buying groups assure true choice for consumers. Consumers should have the maximum amount of choice possible. For there to be a healthy level of choice available, there must be a healthy number of companies and plans offering health insurance coverage. Monopolistic buying groups could discourage companies and plans, especially small and medium size ones, from expending the capital required to compete, especially in a monop-

listic structure with little or no room for marketing flexibility. Elimination of a large number of insurers will decrease consumer choice, possibly to harmful levels.

Voluntary buying groups will themselves benefit from competition. They will be more responsive, effective, and efficient in serving consumers if they know the consumers have a choice about where they buy their required health insurance coverage.

Voluntary buying groups provide a safety net by allowing a reformed private market to compete on a level playing field and thereby giving the buying group system time to work out any kinks that might develop.

Surely, if buying groups work as well as the designers anticipate, there will be little if any private market left due to competitive pressures. If, however, unforeseen problems develop that need to be fixed, the current system as reformed would remain in place. That is important, especially when you stop to remember that the current system, even without reform, serves over 80 percent of our population and serves them well.

Proponents of exclusive buying groups worry that under a voluntary system, private insurers could cherry-pick, that is, insure the young and healthy, leaving the older and sicker population for the Government to take care of. We believe that insurance reforms will prevent that from happening. However, if necessary, we propose that all plans, not just those inside a buying group, be subject to risk adjustment and reinsurance mechanisms. This guarantees elimination of cherry-picking, and although there will be some additional administrative costs to a universal risk adjuster, that cost will be far less than the cost of the American public losing access to choice and competition, as would happen under an exclusive buying group structure.

Finally, agents are crucial to choice. For many years, agents have reformed the functions of a human resource department in servicing of health care plans to consumers. Under any system, these tasks must be performed, and the agent is best trained, best equipped, and the most cost-efficient person to do the job.

Senator, thank you for the opportunity to testify.

Senator JEFFORDS. Thank you very much. All of your testimony has been excellent and very helpful.

[The prepared statement of Mr. Tedoldi follows:]

PREPARED STATEMENT OF ROBERT L. TEDOLDI

Mr. Chairman and members of the committee, thank you for the opportunity to testify this morning. My name is Bob Tedoldi. I am an agent from Vernon, Connecticut, and currently serve as president of the National Association of Life Underwriters (NALU). I am here today on behalf of NALU and its conference, the Association of Health Insurance Agents (AHIA). AHIA represents some 9,000 professional insurance agents whose primary business involves health, disability and long-term care insurance. Founded in 1890, NALU is a federation of approximately 1,000 state and local associations whose members include over 143,000 professional life and health insurance agents throughout the nation.

AGENTS SUPPORT HEALTH CARE REFORM

NALU and AHIA members support health care reform, and applaud this committee, other members of Congress, the President and others for their efforts to rationalize the health care delivery and financing systems. Each of the reform proposals currently pending has many strengths which we urge you to consider carefully—and enact the best into law. Among the reform measures that we encourage you to adopt

are so-called insurance reforms which would subject all health care plans to guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition requirements, administration and paperwork streamlining, and cost control measures. We understand the need to make sure that the reformed system's costs are as contained as much as possible, and the need for government involvement, especially in the provision of health care to underserved areas and low-income people. We agree that government involvement should enhance what is essentially a competition-driven, private system that guarantees full and free choice for all Americans. We also support an active employer role in the provision of health care coverage for all Americans.

STRUCTURE OF BUYING GROUPS

The President's health reform proposal, along with H.R.3222/S.1579 and the Senate Republican Health Care Task Force proposal, sponsored by Senator John Chafee (R-RI), makes a principal part of health care reform the creation and implementation of a "buying group." The buying groups are intended to consolidate the market power of many individuals and employees of small businesses; streamline administrative and paperwork requirements and realize substantial cost-savings as a result; and also to eliminate, or minimize, risk assessment (of individuals or small groups) as a basis for issue and/or price of health insurance coverage. In the Clinton proposal, the buying group is called a health alliance, and it would be the only way (i.e., it would be mandatory) for any individual or employer group of under 5,000 to purchase health insurance. Under the rules of H.R.3222/S.1 579, the buying group is called a HPPC (health plan purchasing cooperative), with participation in the HPPC mandatory for individuals and for businesses of 100 employees or fewer. The Chafee plan sets up HPPCs, but makes them voluntary for all.

NALU/AHIA believe that to the extent the reformed health care delivery/financing system includes buying groups, participation in them should be voluntary. Buying groups are a largely untested, theoretical concept that may well prove to be effective—but there is also the possibility that unforeseen problems will develop and changes will have to be made. Thus, a period of "testing" the buying group concept, without imposing unnecessary risk to the current system of health insurance coverage, becomes an important safety net. This is what the states of California and Florida did in enacting health care reform. The professional agents represented by AHIA and NALU worked with California and Florida in creating their reforms, and are working with the states' buying groups now. We want to work with the Federal Government on reform as well, and also hope to be able to work with the buying groups, if they result from this reform effort.

A rule that makes participation in buying groups mandatory poses an unnecessary threat, and undercuts the safety net protection needed during the testing period. Because buying groups are built on a theory of market power derived from pooling many individuals, insurance plans must attract a large number of participants in order to compete. Because exclusive buying groups may not allow sufficient flexibility for small and medium sized insurance plans to market in such an environment, there is grave risk—indeed, a high likelihood—that due to capital requirements and market penetration concerns, many—probably most—small and medium sized insurers will be unable or unwilling to experiment in this new environment. If this happens, only a few, large insurance companies and/or provider networks will survive. This in turn will seriously undercut the safety net potential allowed by rules that permit the private sector to compete on a fair and open playing field. It will also substantially limit the choices available to consumers of health care services.

Further, there is substantial agreement both in government and in the private sector that competition is the key to the new system. The President, the authors of the principal Congressional health care reform proposals, health care providers and health care insurers all generally agree that costs cannot be controlled without vigorous, fair competition. The truth of this belief is just as applicable to the buying groups themselves. A buying group will be more responsive, more effective, more efficient and more likely to succeed in its mission of assuring quality, affordable health care to all comers if it is itself subject to full, free, fair competition.

It is important to dwell a moment on the phrase "full, free, fair competition." Neither the insurance coverage available inside the buying group nor insurance coverage available on the private market should be subject to competitive advantages derived from regulatory issues. If plans inside the buying group must provide guaranteed issue, guaranteed renewability, portability, limits on pre-existing condition exclusions, etc.—and they should—then, so, too must plans available outside the buying group be subject to these rules. Insurance reform is a crucial element of

health care reform, regardless of the structure under which health care coverage is delivered to consumers.

The level playing field requirement guarantees that buying groups will not be subject to "cherry-picking," i.e., the practice of trying to identify the healthiest, best risks and thereby leave the less healthy people for others to insure. Some say that a voluntary buying group structure poses the risk of cherry-picking for the buying groups. Others argue that the risk is graver for insurance available outside the buying group. Neither is an acceptable result. Cherry-picking must be eliminated for this system to work.

We believe that the small group insurance reforms which we support will eliminate intentional cherry picking whether buying groups are created or not. However, to the extent Congress creates buying groups and believes that residual cherry picking problems remain, risk adjustment/reinsurance mechanisms which have been proposed to operate on insurance plans inside the buying group could be expanded to apply to all plans, whether available on the outside or inside the buying group.

We have collaborated with the Health Insurance Association of America in creating a rudimentary mechanism. The risk adjuster/reinsurance mechanism would mathematically adjust for claims experience among all health insurance plans. It would calculate a "risk adjustment factor" to account for consumers' use of insurance coverage. That factor would be used to increase or decrease the premium charged by an insurance plan—after the period of insurance—to smooth out inevitable "bumps" in claims experience. It also eliminates any incentive to save money on health insurance by the premium payers by trying to join or form a group composed of only young, healthy participants. In short, it eliminates any benefit from cherry-picking and as a result eliminates the practice itself.

Attached is a paper that discusses our concept of a workable risk adjuster mechanism. We would be happy to explore this further with the committee.

EMPLOYERS SHOULD CONTINUE TO PLAY VITAL ROLE IN HEALTH CARE FINANCING

Currently, over ¾ of all health insurance coverage is provided through employment. Most Americans and their families are covered through employer-provided (and usually paid for, at least in part) health insurance. That crucial employer link between insurance and consumer continues under all the pending health care reform proposals. Employers are required to at least make insurance available, through the buying group at specified workforce size levels, to all their employees, and the President would require employers to pay 80% of the average, weighted premium for all their employees. Even where employers are not required to pay for coverage, they are required to allow payroll deduction of premiums paid to HPPCs to distribute to accountable health plans.

The reform proposals' recognition of the key role of employers in the health care financing system is well-placed. But it needs to focus on one additional element—employers. Whether or not employers are required to pay for health insurance premiums, they most often CHOOSE to pay at least a part of their employees' health care coverage. They have stake in effective, efficient health care delivery and cost. Their workers' productivity is affected, significantly, by this issue, adding yet another element to the bottom line of this country's economy from this issue. Employers must continue to be active participants in the selection process of affordable, quality health care and health care coverage. A buying group that is voluntary is the best way to accomplish this objective.

THE AGENTS ROLE IN CHOOSING HEALTH CARE COVERAGE

Historically, the agency system has been the principal method of distribution for private life and health insurance. Agents are the essential link between consumer—whether individual or business—and the insurance company, providing and servicing the products of the insurer while educating the consumer on how to manage risks and how to make informed choices regarding their insurance purchases. The need for this function continues under the proposals for reforming the system. Although all plans contemplate design and provision of "basic, comprehensive" packages of coverage, there will remain choice, and where there is choice, there is the need for informed, expert guidance in making that choice. Further, there will remain a third-party payment system. Insurance, in whatever form, will be paying for the bulk of a consumer's health care costs. Thus, the need to troubleshoot between the insurer and the provider, on behalf of the consumer, will remain. Therefore, the role of the agent remains.

The agent has proven to be, in most cases, the professional most able to provide expert guidance in making choices, as well as efficient resolution of claims or other problems between the provider and the consumer and the insurer, in the most cost-

effective manner. The Managed Competition Act recognizes this with its explicit language allowing insurance plans to use agents. Even the Clinton proposal, despite its explanatory language that terms agents "outdated" and unnecessary, recognizes the need for advice and guidance in making insurance choices, especially for coverage beyond the basic, comprehensive package. Therefore, it is crucial to acknowledge that although some consumers will take the time and expend the energy to read detailed descriptions of plans and procedures, many, many more will want to be able to call upon a professional to help them sort through what is, after all, a fairly complicated and extremely important issue. We believe many consumers will WANT—and should be able—to keep working with their agents.

What does the licensed, state-regulated professional agent do?

Professional health insurance agents work with clients to evaluate their need for health and other insurance protection. This may involve substantial research and fact-finding about the person's individual and family situation and the available products best suited to meeting the needs of those individual situations. This is an on-going process since needs continuously change as a person's family and employment situation change.

Professional health insurance agents explain the various programs available and relate the elements and restrictions inherent in a given plan to the plan's costs.

Professional health insurance agents encourage their clients to act in a timely fashion to assure that the proper coverages are in place when they are needed. They also see to it that accurate and complete information is provided to the insurer so that the client is sure to get the very best price or premium available.

Professional health insurance agents keep in touch with their clients and review or update coverage on a periodic basis. They suggest changes when appropriate and counsel clients on ways to reduce cost. Often, they assist their clients in reviewing the need for legal and/or tax compliance, and recommend other professionals when assistance such as tax or legal issues arise.

Professional health insurance agents assist with claims, answer questions and serve as ombudsmen in helping their clients deal with insurance companies and, often, with medical services providers. They help clients assemble proper documentation to file or follow up on claims, especially among those agents whose clients are Medicare beneficiaries.

Professional health insurance agents assist business owners in communicating benefit packages to their employees, and often assist the employees in seeing how the benefits coordinate with their personal financial programs as well as those provided by government.

Professional health insurance agents apprise business owners of changes in federal and state regulatory requirements. Agents assist plan owners with compliance problems and procedures.

The helpful role agents play with small business firms was borne out by a poll, commissioned by AHIA and done by Penn-Schoen this past autumn. The poll demonstrates that over 70% of small businesses who now provide health insurance to their employees like, respect and value the services they receive from their agents.

We believe that even after reform, someone will have to provide advice on how and what to choose in the way of the best health insurance coverage for each individual, troubleshoot problems between providers, consumers and insurers. Booklets, brochures, "report cards" and other documents; 800 numbers and other impersonal information sources will certainly work for some consumers. For most, such devices are simply insufficiently responsive to consumer needs. We need look only to the IRS and its documents and information telephone numbers for a lesson in how not to serve the consumer. To be truly responsive in a cost-effective way, the new system needs someone who will look out for the consumer. We believe that that someone should continue to be the someone who performs these tasks so well now: the professional, caring health insurance agent.

TAX, COST CONTROL, PRODUCT DESIGN ISSUES ALSO OF SOME CONCERN

While AHIA/NALU are primarily concerned with the issue of devising the best structure for a reformed health care delivery system, we are also concerned with financing aspects of the reform plans. While we have historically supported tax incentives aimed at encouraging people to enjoy the security of adequate and appropriate insurance protection, we are willing to give serious consideration to such ideas as a tax cap or an employer mandate. These ideas go beyond encouragement and incentive, but may be acceptable if such provisions are drafted narrowly and target accu-

rately our mutual goal of assuring universal access to affordable, quality health care coverage.

However, we must note that insurance companies must be able to create the insurance products we all want all Americans to have. Thus, premium caps and, possibly, pricing restrictions such as pure community rating, to the extent that they make it impossible for insurance companies to offer adequate insurance products, will be a problem for the agents represented by AHIA and NALU. We support the companies in their efforts to work with government to design appropriate cost containment measures.

Mr Chairman, we appreciate the opportunity you have given us to testify here today and we look forward to working with you on this vital issue. For now, I would be pleased to respond to any questions that you might have.

Thank you.

[Attachments to Mr. Tedoldi's statement are retained in the files of the committee.]

Senator JEFFORDS. Our final witness is Alan Katz, with Centerstone Insurance and Financial Services. He is legislative chairman of the National Association of Health Underwriters, from Santa Monica, CA.

Alan, welcome, and please proceed.

Mr. KATZ. Thank you, Senator.

Health Underwriters' members have a unique view of the health insurance reform debate, for we see first-hand every day what is working in the current system and what needs to be changed. That is why Health Underwriters developed a comprehensive reform package called Real Choice. It has much in common with several proposals before Congress and that of the Clinton administration, including achieving universal access to affordable health care through a stable and fair marketplace. It changes the way carriers do business by requiring them to manage risk and not avoid it. It assures many cost containment provisions with the Clinton proposal. These similarities are described in our written testimony, which includes a copy of Real Choice.

I would like to highlight, however, two of the issues where we differ with the administration plan, starting with the matter of health alliances.

For the record, Health Underwriters questions the necessity of Government-sponsored purchasing pools. However, we appreciate the desire of members of both parties to experiment with those arrangements.

The issue is, then, if there are to be health alliances, should they be the exclusive source of health care coverage available to American consumers. Health Underwriters believes that voluntary health alliances competing on a level playing field with private carriers and private health alliances serve consumers far better. Exclusive health alliances, freed from competitive pressures, lack the incentive to provide the quality, service, and performance American consumers have the right to demand. Exclusive health alliances are the equivalent of the company store, that leaves consumers with no viable alternative but to take what they get. That is why The Jackson Hole Group, which developed the concept of health alliances, recently reversed its position in support of exclusive purchasing pools and now rejects them.

Health Underwriters also recognizes that health alliances are experimental; they may not work. If health alliances must compete with private carriers, then consumers cannot lose. Whichever

model best meets the consumers' needs will be the one that prospers. However, if this Congress establishes exclusive health alliances, and if those health alliances fail, an entire infrastructure will have been wiped away.

Exclusive health alliances represents health care reform without a net, and consumers are the ones who will get hurt the worst by the fall.

These are among the reasons that seven of the eight States to have created health alliances have established voluntary ones.

Health Underwriters also disagrees with the administration as to the role of the agent in a reformed system. They seem to view us as part of the problem, not surprisingly, and we view ourselves as part of the health reform solution. We do not believe an 800 number and a Government manual can replace the hands-on, personalized advice and independent advocacy that agents provide their clients. For most small businesses, we are the only human resources department they can afford, and I am sure Senator Metzenbaum will feel comfortable with the fact that there is not a single major medical policy in this country that pays 100 percent of premiums to agents. In most States, it hovers around 5 percent; in some, it might go up as high as 10 percent. But it is nowhere near the astronomical numbers that he was concerned about.

Senator JEFFORDS. He was probably referring to life insurance, wasn't he?

Mr. KATZ. He was. He was referring to life policies.

Further, it is important to remember that agents' primary loyalty is to our clients. If we do not deliver, our clients can fire us at any time. The same cannot be said of the employees of an exclusive health alliance.

Eliminating agents does not eliminate the need to have someone answer consumer questions and solve their problems. The issue is: Will answers and solutions be provided by an agent that knows the consumer, that is accountable to the consumer, or by a full-time alliance employee who has never met the consumer and owes him or her no loyalty?

In California, employers are answering that question in voting for agents with their pocketbooks. Of the nearly 1,200 small businesses that have signed up with the State's brand, new health alliance already, a voluntary health alliance, 79 percent have chosen to use an agent, even though doing so adds, on average, 5 percent to their monthly premiums.

Health insurance agents can play an important role in passing meaningful comprehensive health care reform during this Congress. Agents are active in communities throughout this country. We coach little league and chair the PTA. We lead charities and head chambers of commerce. We serve on city councils and school boards. Health insurance agents can reach out to literally millions of Americans, our clients and their employees.

The professionals who make up Health Underwriters stand ready to use these positions as influence and our insight into the system to work with you and the White House to resolve our differences and achieve not only health care that is always there, but health care reform that always works.

Thank you for this opportunity to address you, and we are all happy to answer your questions.

[The prepared statement of Mr. Katz follows:]

PREPARED STATEMENT OF ALAN KATZ

Mr. Chairman, Senator Kassebaum, Members of the Committee, I thank you for the opportunity to appear before you today to discuss the Administration's proposal for health care reform, particularly the issues surrounding the proposed regional health alliances.

My name is Alan Katz. I am a principal in a general agency in California specializing in the health insurance market. In addition, I am Legislative Chairman of the National Association of Health Underwriters (NAHU), a member of the NAHU Board of Trustees, and Immediate Past President of the California of Health Underwriters (CAHU). With almost 15,000 members, NAHU largest health only independent association representing insurance professionals specializing insurance in the United States.

Our nation faces a unique opportunity to reform our health care system, an opportunity made possible through the leadership of President Clinton. The President and the First Lady deserve credit for placing health care reform at the top of our country's agenda. They also deserve credit for advancing the cause of universal access to affordable health coverage, a goal NAHU strongly supports.

NAHU supports the bulk of the President's plan and looks forward to a constructive debate. We are confident that we can resolve those points of disagreement—most significantly the nature and structure of the alliances that are the subject of this hearing—and achieve in the near future, meaningful health care reform that works for the American consumer.

NAHU has long supported comprehensive market-based reform of the health insurance market. We developed our position after years of experience when, as consumer advocates and advisors, we were forced to inform our clients that their health coverage was canceled; or that it would no longer be affordable; or worse, that we could not find coverage suitable to their needs.

The debate over uninsurable and underinsured Americans is not only a matter of statistics for us; we personally work with these individuals on a daily basis to obtain affordable coverages. They are not just our clients: they are members of our community, our friends, our neighbors, and in many cases, our families. Sometimes—too many times for us—we come up short. Agents believe in reform.

NAHU believes there is much that is good about America's system of health care coverage today. What works now should be maintained. What doesn't work must be reformed. NAHU is committed to comprehensive and responsible health care reform providing universal access to affordable, high quality options in a competitive health care system.

Since the 1980's, NAHU has been on record in favor of market-based reforms that will achieve the six principles of reform that President Clinton has put forward: security, simplicity, savings, choice, quality and responsibility. We have repeatedly offered our strong support for these principles.

Our early commitment to reform evolved into NAHU's comprehensive Strategy for Health Care in America, first developed in 1990. In light of the continuing need for health reform, that Strategy was revised in May of 1993 and re-introduced into the reform debate as REAL CHOICE, a comprehensive strategy for health reform. REAL CHOICE is based on the NAHU's Consumer Bill of Rights, and copies of both are appended to my statement.

NAHU'S PLAN V. THE CLINTON PLAN

NAHU's plan, like the Administration's plan, proposes universal coverage for all Americans. Under the Administration's approach, exclusive government-sponsored health alliances would negotiate with carriers to offer coverage in a region or state. Consumers employed in firms of less than 5,000 employees (and many in larger firms) could purchase their coverage only through their one local health alliance.

The nature of the exclusive health alliances included in the Administration's legislation is somewhat less restrictive than originally proposed in September. NAHU applauds this move towards more competition, but we urge them to move further still. As representatives of the Jackson Hole group noted in testimony (reversing the group's previous position) before the Senate Labor and Human Resources Committee on October 20, 1993, the absence of competition between alliances will almost inevitably lead to a highly bureaucratic organization with a tendency to serve its own interests rather than those of its members.

NAHU's plan places greater reliance on competition. NAHU calls for a system of multiple private alliances, voluntary in nature, all competing in a well-regulated market that features a level playing field. If alliances compete on a level playing field with existing carriers and succeed, consumers will win. If alliances compete and fail to match the efficiencies of the private marketplace, consumers will still win because the reformed marketplace has met their health coverage needs. The marketplace should decide the effectiveness of this new mechanism for the time-proven concept of pooled purchasing power.

NAHU also differs with the Administration with respect to the standard benefits package. The Administration's "one-plan-fits-all" approach eliminates consumer choice and places the government in the paternalistic role of determining what consumers want and need from their health plans. It also will result in tremendous political battles over what is in the plan—and what is not.

NAHU believes that Americans should determine the plan design that best fits their families' needs. Instead of creating a standard plan for all Americans, we propose defining an essential benefit package that all plans must include, while permitting carriers the flexibility of adding additional benefits to meet market demand. To achieve the President's principle of simplicity, common definitions of benefits could be established so consumers could easily understand what their premium dollars are buying.

Under both the Administration's and NAHU's plans, companies would be permitted to fully deduct the cost of their plans. However, under NAHU's plan, employer-provided benefits beyond the essential benefit package would be considered taxable income to employees. This is aimed at controlling costs and encouraging responsible consumer purchasing decisions.

An additional area of contrast comes in the context of mandating coverage. The Clinton Administration proposes to build on today's predominantly employer-based system to require employers to pay 80% of the cost of coverage (within limits) for each employee and dependent.

NAHU also builds on the employer-based system by requiring employers to offer, but not to pay for their employees and employees' dependents' coverage. Instead, NAHU's plan would require individuals to purchase coverage. Subsidies in the form of refundable tax credits or vouchers would be available to assist low or moderate income individuals. NAHU proposes a full subsidy for up to 200% of the poverty level (about \$28,000 for a family of four) and a partial subsidy for up to 250% of the poverty level.

Both plans would require comprehensive carrier reform. Both plans require guaranteed access, guaranteed renewability, and fully portable benefits for every American.

It is worth noting that 31 states have already enacted guaranteed access provisions and 44 states have enacted provisions promoting portable benefits. These state reform efforts are benefiting consumers throughout this country and should be encouraged in those states that have not yet enacted market reforms.

NAHU and the Clinton Administration also agree on the need to reduce paperwork. Both plans standardize claims and applications forms, and would move towards paperless transactions.

One area of significant difference between NAHU and the Administration is price controls. Under the Clinton plan, if spending exceeds targets, caps on spending would be implemented.

Although insurers and providers would also be adversely affected by price controls, we fear consumers stand to lose the most under caps or global budgets. With respect to the Clinton proposal, "health security" or "health care that is always there" is undermined if access to care is rationed, and simplicity is sabotaged when incentives for gaming the system come to dominate. In addition, price controls in other areas of the economy failed to work for former Presidents Nixon and Carter; there is absolutely no reason to assume that they will work now. Market-based incentives are more likely to control costs than price caps.

Finally, the Clinton Administration and NAHU differ dramatically on the appropriate role of the professional agent in the health care system. The Administration proposes that alliances maintain exclusive control over the marketing of approved health plans. Agents are to be replaced by printed report cards on participating plans, interactive media, and advertising.

We do not believe any "1-800" number, gray government manual, interactive technology, or any other new system can adequately replace the hands-on, personalized advice and independent advocacy that agents provide to their clients. Although the Clinton Administration wants to believe insurance agents are part of the problem, we believe, health insurance agents are actually an important part of the health care reform solution. Perhaps the Administration is not aware that:

Agents help more than 200 million Americans gain access to health care security.

Agents are the consumers' advocate fighting bureaucracy—public or private—to get consumers the benefits they deserve.

Agents are the "employee benefits department" for millions of small employees who cannot afford a all-time human resources department.

Agents are cost-effective, compensated only when clients consider them valuable. Agents can be fired at any time the client is dissatisfied with their service.

Consumers are aware of this reality. Consider the evidence from my own state of California. Under legislation authored by Assemblyman Burt Margolin, California's health alliance began operations on July 1 of this year. That health alliance, known as the Health Insurance Plan of California (HIPC) is open to small businesses with five to 50 employees. Already over 1,000 California firms have signed up for the state's new health alliance. More than 78 percent have specifically chosen to enroll through agents.

The state agency overseeing California's HIPC recognized that agents add value to products we sell and service. Small employers are voting with their pocketbook that they agree. These business owners recognize that professional agents do far more than merely sell health insurance. Rather, we spend the majority of our time servicing our clients. Consumers will always have questions and, regardless of the best intentions, they will always face problems. Agents are who consumers turn to—and want to turn to—for answers and solutions. Agents who meet the ongoing needs of their clients succeed. Those who don't get fired. It is that simple.

Still, NAHU does not insist that all health plans be required to distribute and service their products through agents and brokers. We simply believe that health plans should not be prevented from employing agents and brokers when they choose to do so. Whether to use "W-2" employees or "1099" agents should be a business decision left to the carrier—or health alliance—and not subject to micro-management through legislation.

In sum, both the Administration's and NAHU's plans seek to provide universal access to affordable health care and to reduce the increase in overall spending on health care. Both reject an exclusively government run system by relying on private carriers and providers. The most significant area of disagreement, however, lies in the respective degree of government intervention into the marketplace.

HEALTH ALLIANCES

The Administration can easily accomplish its objectives without creating exclusive purchasing cartels. Yet, they have articulated an inflexible position on this issue, so allow me to explain why they will not work as the Administration has proposed and what can be done to improve them—without creating new government bureaucracies and without the government making the leap from regulator to competitor in the marketplace.

Members from both parties are interested in experimenting with purchasing pools. If health alliances are to be part of the ultimate reform package, NAHU urges Congress to recognize that they are experimental and treat them accordingly. We strongly urge that any and all health alliances be privately organized and voluntary in nature and be required to compete on a level playing field with other health alliances and with private carriers operating outside the alliance structure.

This is the approach taken by seven of eight states that have already passed legislation establishing health alliances. It is how the nation's first operational health alliance, the Health Insurance Plan of California, operates. And it has several advantages over the exclusive health alliance model.

When health alliances compete on a level playing field with private carriers they have a strong incentive to provide top quality customer service. If they fail to do so, they lose business. Exclusive health alliances have no such incentive. This reality has led the Jackson Hole group to recognize that they were wrong in calling for exclusive purchasing cooperatives.

When health alliances compete on a level playing field with private carriers they tend to improve the offerings of private carriers and are forced to improve themselves. Competition between the California health alliance and the private sector has improved both the state plan and private carriers.

When health alliances compete on a level playing field with private carriers they have the chance to prove themselves—without endangering consumers. Health alliances are experimental. They may thrive or they may fail. If they thrive by better meeting the needs of consumers, consumers win. If they fail, it means that entrepreneurs are better able to meet the needs of consumers, and consumers still win.

Voluntary alliances are the only sure way to guarantee that consumers come out ahead regardless of the results of the experiment.

Proponents of exclusive health alliances will argue it is the only way to eliminate adverse risk selection. However, this argument fails to recognize that health alliances are to be created within the context of other far reaching reforms, most notably the requirement that all health plans be made available to all consumers regardless of their risk factors. If health alliances and private carriers offer products containing the same essential benefits and on a guaranteed issue basis, there is no reason why the health alliance should receive more than its share of high risk individuals.

The necessary mechanism for adjusting any remaining risk between health plans operating in a system of multiple voluntary private alliances is identical to that envisioned under exclusive health alliances. There is no need to duplicate this expertise from alliance to alliance; rather, state departments of insurance—somewhat ignored under the Clinton plan—can serve in this role.

There is also no reason why meaningful, comprehensive health care reform cannot be achieved in this Congress. The challenge is great, but so is the need for action. NAHU has offered a recipe for change that has numerous elements in common with the Administration. We stand ready to work with you and the White House to work through our differences.

Thank you for your attention and I will be pleased to respond to your questions.

[Attachments to Mr. Katz' statement are retained in the files of the committee.]

Senator JEFFORDS. Thank you. I think I am going to take the luxury of asking some questions, although Senator Kennedy will be asking his via writing. I have about two other places I am supposed to be right now, but this is very important to me.

First, you talked in terms that insurance reform would reduce, or eliminate, basically, risk screening and the problems involved with that. However, from evidence we have had at a previous hearing, there are other problems which are related to that which I do not think would be solved. One has to do with competitiveness among businesses. But it would not prevent, especially with the self-insured, the ability to risk-screen at the employment level, would it? If you are self-insured, and you make up your mind, "Well, let us make sure that we only hire young people up to the age of 40; no one is going to stay with us longer than that. And we will also, to the best we can, make sure they are good and healthy when the come to us." The voluntary system would not prevent that, would it?

Mr. MAUK. Well, in one way it could, if you require community rating; then you could not discriminate, even in the self-funded plans. So if you had a system where in fact everyone had to abide by the same rules, whether they were self-funded, whether they were in alliances or out of alliances, with community rating, you could do that.

But the problem would be that in fact many people would not opt to be in the system if they were healthier, and therefore the rates would be higher, unless everyone was required to be included.

Ms. LEHNHARD. I think by definition if you are going to allow self-funding, community rating does not address it, because the employer who self-funds only has his experience to worry about.

We have supported moving away from self-funding in the lower end of the market for a number of reasons, and this is one of them. It may well be that small employers are more prone to worry about the health care costs of their employees because they do not have a big group of people to pool that risk among, and this may again be another reason to leave self-funding to the larger end of the

market and move the smaller end of the market into large purchasing pools that are supposed through community rating.

Mr. KATZ. Senator, I would just add that there are various laws that would prohibit discrimination based on age, disability, and in California, lifestyle. There are a number of factors outside of health care reform that could prevent that kind of cherry-picking by the self-insured. Once they are in a plan, I think we all agree, as does the Clinton proposal, that everyone has to play on a level playing field, including the self-insured plans.

Senator JEFFORDS. Well, I think the Clinton plan would solve that problem, but I am just concerned that there are things that may be technically legal, but difficult if not impossible to prove on the discrimination end that affect your health care costs.

The concern was expressed by unions—of big automobile companies, to be honest with you, just to give you that information—who are seeing the foreign competition coming in from overseas, wherever they may be, and opening up nonunion situations by hiring basically young workers and seeing their health care costs substantially lower, and providing no income security in the sense of pension plans. So there is a whole pension area which gets involved here, which concerns me as to making sure that we provide a system which will also ensure that we have pensions when we are finished. There is no sense living a long life if you end up living in a one-room apartment somewhere in the back of a garage. So we want to try to make sure we do that.

Another question I had was, isn't there another problem with the voluntary alliances and employer choice, that you do not solve the problem that if they lose that job, they will be able to get another one? How is that aspect handled?

Mr. KATZ. Senator, under the Real Choice proposal and many of the other proposals out there, all coverage would be guaranteed issue. So if someone loses his job which currently provides him with health care coverage, he would be able to move into a marketplace without having any of his existing conditions excluded, without having to pass through an underwriting hoop. There would be guaranteed issue, guaranteed renewable, and they would be assured of getting the coverage elsewhere.

Other models also permit them, much like COBRA works, to carry along their existing group policy as well. And the fact that it is exclusive or nonexclusive health alliance really does not affect that.

Senator JEFFORDS. Ms. Lehnhard.

Ms. LEHNHARD. Senator Jeffords, there is a related issue that you may be getting at. While insurance reform would say no pre-existing conditions, and universal coverage would assure you had coverage when you move to a new job, I think one of the rationales offered for a mandatory alliance has been that if people move more and more into managed care networks, where you are really picking your physician, it was thought that you should be able when you change jobs to stay in that network and take the network with you.

We have no problem with that, but we think the alliances are so untested that to do fruitbasket upset in a community and move from several hundred employer choices to hundreds of thousands of

individual choices and transactions is too much. That is why we are supporting voluntary alliances, and we said the sole purpose should be to support individual choice for small employers. The employer of 12 goes to the voluntary alliance, offers a menu of choices to his employees, and we begin to get some experience with individual choice.

We just have a feeling that there is so much that could go wrong with the alliances if you put all your eggs in that basket. You will not see reform in a hurry, and you could see something happening in a community that would cause great disruption to the consumers.

Mr. MAUK. I think one of the issues you are getting at is if you have volunteerism in terms of the employer providing health insurance, if someone moves from one job to another, there may be none available. And that would in fact therefore restrict flexibility in terms of a person's choice and where they would like to be employed.

I think, just to follow up on a comment that Mary made, there is no question that a massive change all at once could be very disruptive. People who have current plans, if they are required to be in health alliances, there may be different plans with not the same doctors, and things like that. So while there needs to be a transition, the question, though, becomes one of is there enough economic clout for provider, for the health care plans, to really negotiate legitimately with providers and other givers of care, in terms of really getting prices down and really influencing the increases in cost. And that seems to me to be the union that you have to put together.

If you are going to require people to be in the system, there needs to be some real consideration of what the predictions are in the future, and it has to be real as far as what they are going to be paying. Therefore, you need real cost savings and real cost control. Therefore, you have to look at different mechanisms to do that.

Hopefully, it will be managed competition, hopefully, it will be through the alliance process. But even beyond that, if that is not going to be there, we need to have regulatory interaction that can assure people that if they are going to be in, the costs they are going to be paying for health care are not out of their ability to pay.

Mr. TEDOLDI. Senator, I want to go back to the question of risk adjustment for the self-insured. In my written testimony, there is a model of what a risk adjuster could look like, and our presumption is if we are for universal coverage, portability, and guaranteed insurability, and for a level playing field, that is, plans inside and outside an alliance would have to all play by the same rules.

The risk adjuster then would be applied to all plans, including self-insured plans, and they would have to be accountable for their part in the cost of the system and then adjust accordingly.

In the area of portability, I think that is doable. I think if we are buying into the process, and we are going to allow voluntary plans to provide services and health care to our consumers, then portability will be part of the price they will pay to be part of the system—as will, by the way, doing away with limits on pre-existing conditions, which by the way will allow you to go from plan to plan.

Now, Mary mentioned that you might have the problem of leaving one plan or provider and going into another, but if you are getting new employment in the same area, I would suggest to you that the plans would be available on a portability basis.

Senator JEFFORDS. Any other comments?

[No response.]

Senator JEFFORDS. Is there anything else anyone would like to say before we bring the hearing to a close—I will give you a softball.

Ms. LEHNHARD. You have been very patient.

Mr. KATZ. Thank you for staying until the end.

Senator JEFFORDS. All right. Thank you all very much.

The hearing is now adjourned, subject to questions from members.

Thank you.

[Whereupon, at 1:22 p.m., the committee was adjourned.]

LONG-TERM CARE: SECURITY FOR SENIOR CITIZENS AND INDIVIDUALS WITH DISABILITIES

WEDNESDAY, NOVEMBER 10, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Harkin, Mikulski, Wofford, Kassebaum, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

I would just take the prerogative of the chair while we are waiting for members to arrive, to recognize the Paralyzed Veterans of America who are attending our hearing today. If they would show their hands, we want to thank them all very much. I understand these are the members of the board who are here, and we thank them for attending today.

We have a very interesting group of witnesses this morning, and I will take the opportunity to introduce them in a moment.

The first principle of President Clinton's health care plan is health care security for all Americans. When the First Lady testified before this committee, she also stressed the importance of having health care that is always available and affordable.

Today we consider an essential part of any guarantee of health care security—long-term care. That concept includes a large variety of health services for those who need assistance, day in and day out, for long periods of time. Ten million Americans of all ages and with varying types and degrees of disability need long-term care.

Those who require such care often include children whose physical disabilities or mental retardation require constant attention. Americans of all ages can fall victim to automobile accidents or other injuries that leave them incapable of caring for themselves. In many cases, long-term care can lead to the kind of rehabilitation they need to function independently again.

Millions of senior citizens also suffer each year from the debilitating illnesses that accompany old age. They too need long-term care.

Friends and families of the ill or disabled often make great sacrifices that affect their own health, careers, and economic well-

being. These devoted families and friends are the invisible victims of the Nation's inadequate current system of long-term care, and it is time their needs too are recognized and met.

Home care and community-based care are equally important aspects of this issue. How and where care is provided is as important as treatment itself. My family was fortunate enough to be able to give the best in home care to my mother, and it has also enabled her to remain close to her children, her grandchildren, and now her great-grandchildren, which has enriched all of our lives.

The centerpiece of President Clinton's long-term care plan is a program to finance home and community-based long-term care for our most disabled citizens. I am concerned, however, that the plan does not include protection for the cost of nursing home care.

I plan to introduce, along with Senator Wofford, a separate bill to give older Americans the opportunity to voluntarily purchase a nursing home policy from the Federal Government. The program would be self-financed by policyholders and would be affordable for middle-income families.

A coalition of concerned organizations, including the American Association of Retired Persons, the Alzheimer's Association, and the Consortium of Citizens with Disabilities have made a videotape about these problems, and it is an extraordinary testimony to the plight of those who need help.

After we see the videotape, witnesses and their families will answer questions from the members of the committee.

Before we begin I have statements from Senators Dodd and Wofford.

[The prepared statements of Senators Dodd and Wofford follow:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, our topic today, "long-term care: security for senior citizens and individuals with disabilities," is of critical importance to thousands of Americans who have fallen through one of the biggest holes of our present health care system: its lack of coverage for long-term care.

This deficiency in the system bankrupts many of our families and strikes fear in the hearts of many others who fear that they too will lose everything they have to pay for long-term care.

I am glad that we will hear today from several Americans who have first-hand experience with the issue of long-term care. I think their testimony will provide us with the kind of human perspective on this problem that we need.

I would like to add a voice from my own State of Connecticut to theirs. Earlier this year, I received a letter from a 65-year-old resident of Stonington, Connecticut. I think his words speak for themselves, and I would like to share some of them with my colleagues:

"I care about health care deeply. My mother died in a nursing home at the age of 83. She worked hard all her life for her home and a small savings. She struggled for years on social security, but with inflation, increased cost of health care and her yearly increase in property taxes, she lost everything.

"The family helped in every way possible until she needed around-the-clock care. She was a loner like most old yankees and

she died of a broken heart. With all the family visits and much of our love, she just gave up. A sight I will never forget.

"Now I am at the age of 65 on a fixed income, and I can see in just the last three years, my wife and I are headed for the same fate, it will only take time. I pray every day I may live my latter years with dignity and not a burden to my children.

"Please make every effort to help us with long-term medical care, prevention and prescription drugs. We are more than willing to pay our fair share of the cost."

I think that is a powerful statement about the stakes of this discussion today. For many older Americans and Americans of all ages with disabilities, long-term care is by far the most important part of health care reform.

Long-term care is not only a drain on family finances, it is also badly straining State finances. My own State of Connecticut has been particularly hit by high long-term care costs. Of Connecticut's \$1.8 billion in medicaid expenditures in fiscal 1992-1993, \$787.5 million went to long-term institution care and \$59.3 million went to home health care.

In fact, long-term care comprises more than 10 percent of Connecticut's entire state budget. This bears repeating: one of every ten dollars the Connecticut governments spends goes to pay for long-term care.

The Health Security Act contains some desperately-needed new provisions for long-term care. Starting in 1996, a new home-care and community-based care program would allow many disabled older Americans to receive the care they need in the comfort and security of their own homes. This type of care is not only preferable to many Americans, but also is more cost-effective than institutional care.

Medicaid's coverage of nursing home care would also be strengthened to allow nursing home residents to keep \$70 a month for living expenses. Furthermore, States would have the option of providing still stronger protection by allowing individuals to protect \$12,000 in assets, rather than the \$2,000 allowed today. The bill would also provide tax incentives to encourage individuals to purchase private insurance policies with long-term care components.

In addition, the Health Security Act will devote resources to enable thousands of people with disabilities to educate themselves, to enter the work force and to take part in the community around them.

I look forward to learning more about these provisions and hearing ideas from today's witnesses about how we might improve on them.

PREPARED STATEMENT OF SENATOR WOFFORD

In November 1991, Pennsylvania sent a wake-up call to the people here in Washington. Our message was that there's a growing health care crisis and it's time to do something about it. Part of this crisis is the lack of adequate protection against the often staggering cost of long-term care. I believe that health care reform legislation must address the long-term care needs of Americans of all ages.

Older citizens have worked hard all their lives to earn a secure retirement, but this security is too often threatened by the cost of long-term care. Millions of severely disabled elderly Americans need home care or nursing home care today. Forty to fifty percent of all senior citizens alive today will need nursing home care at some point in the future. Few can afford that care—even fewer have private insurance protection.

Public assistance for long-term care is only available once a person has spent their life-savings and become impoverished by the cost of care. Our society is currently paying for long-term care, but we are doing so in cruel ways.

Long-term care is not just a problem for the elderly. Few families are prepared either financially or emotionally to take full responsibility for meeting the challenges of providing long-term care for parents who need it. Chronically ill children and the adult disabled, population also have significant unmet long-term care needs. These individuals and families deserve our help.

I applaud the President for identifying long-term care as a necessary component of health care reform; and I strongly support the inclusion of long-term care in health reform. Of the major congressional alternatives that have been laid on the table, the President's plan is the only proposal that includes any serious attempt to meet the very important long-term care needs of persons with disabilities of all ages.

I believe that the debate on health reform allows us to seriously reconsider the role of Medicaid in the provision of long-term care and to lay the groundwork on which we can expand coverage for long-term care over time.

Our current system of public financing emphasizes institutional services for long-term care needs, which is the right choice for many, but not all. Through health reform we must, at the very least, work to put home care options on a par with options for nursing home care.

We must also work to change the current policy that only provides coverage for long-term care after people have impoverished themselves. I believe that senior citizens and disabled persons deserve the same kind of protection against the cost of long-term care that Medicare intended to provide against the cost of hospital and physician care.

The President's proposal takes a strong step in this direction for persons needing home and community-based care. On the nursing home side, however, I believe that more can be done to ensure adequate protection against the cost of extended nursing home stays without establishing a new federal entitlement program. That is why I have been working with Senator Kennedy on a proposal, which we will introduce shortly, to create a public voluntary insurance program to cover the costs of long nursing home stays.

In recent years, to fill the gap in long-term care coverage, the private industry has begun to offer policies that promise protection. The number of citizens with long-term care policies has doubled in the past three years. But the rapid growth is accompanied by a number of serious problems such as high lapse rates and the lack of inflation protection. I support the provisions in the President's proposal that reflect the provisions of the Long-Term Care Insur-

ance Improvement and Accountability Act that I have joined Senator Kennedy in co-sponsoring.

I look forward to hearing the testimony of our witnesses today and I look forward to working with them to ensure that whatever health reform proposal is ultimately approved by Congress includes provisions that respond to the long-term care needs of Americans with disabilities of all ages.

[VIDEOTAPE SHOWN]

STATEMENTS OF KATE AND TOM MILES, AND SON ROB, LUSBY, MD; SHIRLEY REED, WASHINGTON, DC; BILL SMITH, CHESTERTOWN, MD; AND JUDITH AND OTTO MENKES, BETHESDA, MD

The CHAIRMAN. We thank all of our witnesses for being with us today. I think we are all very much inspired by all that you do for so many other people.

As we really delve into the whole health care issue, we are going to hear a lot about costs, the make-up of the alliances, transition—can we move from this system to that—but what we do not measure is the cost of the anxiety to families like this who are unable, in the richest country in the world, to get the rehabilitation which is necessary, to get some help and relief from some of the care they provide at home. These are people who care about their families and would be willing to take care of them if they can get some help and assistance.

That is a very fearful indictment of our society and our country, as a caring country, that we have just not been able to develop the kinds of systems to be able to do that.

So we are strongly committed to doing something about it, and we are grateful to all of you for being willing to come here this morning and speak about these matters. We know it is difficult. No one could watch that videotape and not understand that.

So we appreciate your being here, and I think the best way we can ever thank you is to get a bill, get it done. I know I speak for all of us here when I say that we are going to do that.

I will start with Tom and Kate Miles. You mentioned that you work two jobs and had to sell your home to care for Robby; is that right?

Mr. MILES. Yes.

The CHAIRMAN. What sacrifices will you have to make down the road in order to continue to care for Robby yourselves, without any help with long-term care services? And when we talk about long-term care services, no one is looking for a handout. These are all working Americans, and what has happened to each one of them could happen to any one of us, so we are talking about our fellow citizens, all Americans.

But let me ask you what you are anticipating down the road in order to continue to care for Robby without any help? If you do not get this kind of help, what kind of pressure will that put on you?

Mr. MILES. Possibly a decision will need to be made concerning Rob living at home; he may not be able to. I mean, we just may not be able to keep him at home.

The CHAIRMAN. Mrs. Miles, you have said that you are willing to stay home and care for Robby, but you need a little help. What sort of help do you need?

Mrs. MILES. I do not need an R.N. He does not need somebody to give him medicine or do treatments or anything like that. Robert weighs about 25 pounds less than I do right now, and like Tom said in the video, he is going to grow up—and my father was 6-foot-6, and I am afraid Robby is going to be that tall.

Up until a year ago, I was carrying Rob, and I can no longer do that. I need somebody who is strong—not a frail person—I need somebody who is strong to come in and do the physical lifting that is involved with dressing him and getting him out of bed.

Tom is starting to have back problems as well, and he has to give Robby a bath.

Mr. MILES. I would just like to say that if we had the help she is talking about, I would think it would be less of a burden financially on our system, because we would only need some help in the home instead of having to have someone take care of him all the time at an institution, which would require a lot more.

Mrs. MILES. Not only that, but I do not think Rob could thrive in an institution. He was in a group home for a year and a half, and I will share an experience. He used to come home every weekend. Tom took him back one Sunday evening. I will never forget it. He came home late, and I could tell he had been crying. When I asked him what was wrong, he said he dropped Rob off, and Rob went into the room where all the other kids were, and Rob put his head down in between his knees, not knowing his father was watching him, and just started crying. And nobody comforted this child. He was not happy because he wanted to be at home with his family.

I do not think any one of us want him away from home any more than he wants to be away.

Mr. MILES. I would just like to see the incentives to keep the family together.

The CHAIRMAN. Robby, how are you? I saw you watching yourself in the film. We are really glad you are here.

I remember a hearing we had 12 or 15 years ago, where we had a family with a child with spinabifida. I remember it very, very clearly. The mother was a school teacher, and the father was a construction worker. And we heard how it just depleted the whole family, and how they finally ended up having to put the child into an institution. It was just heartbreaking circumstances.

And we had the contrast with a feature of the Canadian plan where the parents had four children, and when two of them graduated, they took two children out of institutions and brought them into their home; and when the third child got out, they brought another one in; and when the fourth child graduated, they brought another one in. So there were incentives to keep families together. The health care program provided the resources, just to offset the health care costs for this family, and the family was glad to do it because they wanted to teach their other children what love was all about.

You point out the complete disincentives that we have in our health care system to keep families together, and I think that is something that clearly has to be changed.

Mrs. REED, your daughter suggested you just need some respite care. What sort of help would that be?

Mrs. REED. For instance, I have been up since 2:30 this morning, so if I drop off to sleep, do not pay me any mind.

The CHAIRMAN. We are accustomed to that happening when we speak around here. [Laughter.]

Mrs. REED. My father is paralyzed, and he cannot do anything for himself. So before I came here this morning, I had to dress—he has what they call ulcers or pressure sores; now he has the air mattress, which seems to be of some help—so those had to be taken care of, as well as cleaning his mouth. And this morning, it seemed as though he brought up more phlegm than normal. We wash his face, exercise him. We do not have any therapy. They expect me to exercise his arms and legs twice a day, and he also has to have dressing changes three times a day. And you prepare breakfast, and you prepare lunch, and you prepare dinner.

I start off with 4 hours from VNA when he first came home January 25th. They have now cut me to 2 hours, and I get an hour and a half in the morning because they said the 2 hours includes travel time. So he will get his bath.

Now, last February, I applied, and now we have 2 days a week for 3 hours on Tuesdays and Thursdays in-home support services under the department of human services. The best thing I can have him to is to iron for me, because it does get piled up.

So without the church—in fact, our associate minister is there now with my father—and with the three daughters I have here, with them coming—they have their own assignments that they made up themselves—in the evenings, it is a help.

Now, Saturdays. At first when my father came home, they gave me Saturday and Sunday until we could adjust. So unless I get outside help on my own and pay for it, I have no Saturday and Sunday help as far as VNA is concerned.

The CHAIRMAN. I understand your daughter thinks you need more rest.

Mrs. REED. Well, I think she thinks so, too.

The CHAIRMAN. How has caring for your father without professional help affected your own health?

Mrs. REED. I have tried to be a nurse, but basically, I retired after 38 years of Government service and raising seven children. I have been retired 3 years, which is a blessing. My mother passed December 9, 1992. So it is really a blessing, and I have to thank the good Lord for it, to be retired, because if I were not retired, he would have to be in a home, because basically, it is round-the-clock care.

Now, there may be some mornings where he may sleep until 6 or 7 o'clock, but then there are times when he is up at 2:30, and I have to make him comfortable until he goes back to sleep. And this morning, I guess because I had to come down here, he was still awake when I left home.

The CHAIRMAN. I have extraordinary admiration for your dedication and love.

Mr. Smith, as I mentioned before, I know it is difficult to talk about these matters. But could you tell us a little bit about who takes care of you every day and what they do and how your disabilities have affected their lives?

Mr. SMITH. Right now, I am living with friends of mine. I am not on medical assistance or anything, so the only way I can pay them is with my Social Security. I have applied for medical assistance, but I am unable to get it because my Social Security is so high that I have to go through a spend-down. How that usually works is that for 4 or 5 of the 6 months that I get medical assistance, I do not get it, because I have to do the spend-down. So what that leaves is that I am—I do not know if you would say “a burden”—but I am living with another family, and they are taking care of me 24 hours a day pretty much; they are there when I need them. If I get sores, they help tend to me. They fix meals, help me get dressed and help me shower. And like I said, the only way I have to pay them is with my Social Security, which only works out to \$5 an hour for 4 hours a day for 5 days a week. And they are there 7 days a week.

The CHAIRMAN. You are interested in being self-reliant and independent. You mentioned that you want to get back to work, and you need some rehabilitation, but you want to be a constructive and productive member in our society. That is certainly what we heard you say, and yet we have a system that drives you back the other way and does not provide the kinds of services and help and assistance for you that will permit you to be that way. So that is something else which has to be changed in our health care system.

What happened to your business after the accident?

Mr. SMITH. Well, we had a really hard time trying to get me on medical assistance to get through the initial rehabilitation to help pay for the shock trauma and so on. If I had any assets or anything, I would never be able to get onto it. And my business was not big enough where I could pay my own bills and pay for all the hospitalization and everything. So the business pretty much folded up.

The CHAIRMAN. Did you have some employees?

Mr. SMITH. Yes. I was a partner with my brother-in-law, and he tried to carry it on for a little while, but without me there, he was not able to carry it.

The CHAIRMAN. So another result of all this is that there are some people who have lost work and obviously, because of the lost work, there is a loss in taxes and contributions to your community. It is just going the wrong way.

Mr. SMITH. Exactly.

The CHAIRMAN. That does not make any sense.

Mrs. Menkes, could you tell us a little more about your husband's illness and what sorts of things he has trouble doing now?

Mrs. MENKES. Well, at this point, about the only thing he can do is feed himself, and that is slipping a bit. So I feel like we are a combination of all the other stories here. I, too, am up at night. As you can see, he likes to sleep at this time of the morning.

The CHAIRMAN. He was pretty jolly in the other room, and he was smiling in all the pictures, too.

Mrs. MENKES. His internal clock is off, which is very common with Alzheimer's patients. He will very often lie in bed until about

2 o'clock in the morning. Whenever I wake up, I check on him, and if he needs changing, I do that, and walk him around, and then he will usually fall asleep.

So the afternoon and evening hours, he is his perky self again. But I got him up earlier than usual today.

I would like to point out that it is not only the physical burden, of course, as you have heard from everyone. It is the emotional strain and the fact that your world becomes very, very small. So that unless we do get respite from more than one source—I have a day center very close to us, which is excellent, which Otto attends 4 days a week. I would be desperate without that—or, I would have to have someone in the home. And I think for him, it is a lot better to have the stimulation of the day center. But that is something that not everyone can afford, although they do have a sliding scale.

In addition, my daughter comes on Saturdays. When our son lived here, he used to come on Sundays. And our older daughter gave me a weekend away recently. But I have not been away for more than 3 days in a lot of years.

Right now, I think it would be really helpful if I could have someone strong to come in in the morning and give him his shower, because I have to lift his legs in and out of the shower; I have to lift him in and out of the car. And I hurt my neck doing something else, but it is almost impossible for that tendon to heal while I am doing all these things for him.

The CHAIRMAN. Well, I think you and your daughter are obviously, as others are here, just extraordinary human beings. Other people wake up in the morning and think about the difficulties and challenges they are facing, but all of you are inspirational figures in terms of being willing to help a loved one, and with tragically little help and support. The help they need may vary, as exhibited here, but as a society, we ought to be able to develop the kind of supports needed and, as is illustrated by all of you here, do it in a way that is going to save the system a very significant amount of resources. We will attempt to do that.

Senator Durenberger.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Mr. Chairman, I would make one observation. First, I apologize. I came here, I thought, on time, and the door was accidentally locked, so I went down and got a cup of coffee not knowing I was going to miss a really tremendous presentation on the lives of a lot of people that I would like to know better.

Second, Mr. Chairman, on the observations that everyone here has made, in our own States we are blessed to be able to live with people like the Miles and Bill and the Menkes and Mr. Reed. We are constantly struck by the fact that our efforts, particularly the governmental efforts, to make access to care affordable, always lag behind the reality of what we think we could do "if only."

So having this hearing in the context of reforming health care and forcing us, Mr. Chairman, to think about health care in a much larger context is a real blessing that you bring to all of us.

I would like to make just one observation as it relates to some of the tools that President Clinton is proposing we use. For example, accountable health plans [AHPs]. We have not talked a lot

about accountable health plans, but I have seen around this country experiments making better use of public reimbursement. I remember about 10 years ago going to the Ahnlich Center out in San Francisco, where they are blending medical assistance money with social service money, saying, "see what you can do better for people."

I think about the social HMO experiments in our communities. I think about the incredible number of ways that people with disabilities have shown us how our lives in the larger sense can be made better, for less money, if we find a community-based, family-related way, to deal with these problems.

I think about the living at home/Block Nurse Program that we are helping to fund, which started in my community.

Now back to the idea of accountable health plans. Mr. Chairman, we think of accountable health plans as traditional insurance companies. But in the context of health reform, they will be much more traditional than that. AHPs are going to pick our doctors and hospitals for us. For instance, this is unfamiliar to us and makes many of us a little wary. But if we can put down the idea of health insurance as merely a bill-paying service it will be easier to see the benefits of AHPs. The benefits are that there are going to be accountable health plans, businesses in effect, that will help to tailor services to the people in each of our communities. In each of our communities, these plans will be different. These plans will be able to provide opportunities for access to a whole new creative set of services—and they will not be the same in every community, which is the problem with Government-run programs. They will be different for different kinds of people in different situations.

So creativity—and I am just beginning to see it in my own community, Mr. Chairman, and I think there is some of this in Massachusetts as well—can empower these accountable health plans to take the money we are willing to spend where we have to subsidize access, and provide them with incentives to go find creative ways to meet people's needs in the community. These are the one-on-one ways, the extended family ways, neighbors helping neighbors—innovative ways to improve the quality of life and health care and reduce the rise in costs. This is something where I believe the concept of the accountable health plan, which the President has adopted here, and which we will hopefully adopt in each of our communities, has tremendous potential to help us deal with some of the problems that you are making it possible for us to observe today.

Thank you, Mr. Chairman.

The CHAIRMAN. It is my understanding that the Ahnlich program is being replicated in a number of different communities, and it is completely consistent with the Clinton program as well. We ought to sharpen up and get a look at it. But that is my understanding, and that is a hopeful sign.

Senator Mikulski.

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman, for organizing this hearing.

As the chairperson of the Subcommittee on Aging in this committee, I welcome all of the participants. I know three of the families

are from Maryland, and Mrs. Reed, we feel that you are our cousin from the District of Columbia.

I would like to salute the families in this panel for their devotion, their dedication, and their self-sacrifice in terms of having their families with them at home and trying to maintain as much independence and self-sufficiency as possible.

I know that each and every one of you in your own way lives the 36-hour day. Twenty-four hours a day are devoted to the person at home with you, that you care for, and because they are at home, that care is 24 hours a day, 7 days a week. And then there are the other 12 hours during the day, where you need to take care of other responsibilities. That is why I know each and every one of you lives the 36-hour day.

I probably know it best because, Mrs. Menkes, my own father died of Alzheimer's. Listening to the testimony here today is in some ways "déjà vu all over again."

And to the Miles family, oftentimes when I call my sister Chris, I have gotten the last digit wrong and dialed another number in her neighborhood belonging to a woman who has a son very much like Rob. So I became a "telephone pal" inadvertently because of not remembering my sister's last digit, and I have been in contact with that family in the Dundalk area very much like your own.

I say that because first of all, I wanted to compose myself, because listening to this testimony reminds me of what my family went through. And what we are going through is I think what you went through, which is that long-term care is not synonymous with nursing home reimbursement. I think that is the first benchmark thought that we have to keep in mind.

Whatever we do to meet the long-term care needs, long-term care is not synonymous with nursing home reimbursement. I believe that what we benefited from in our own family was, first of all, geriatric evaluation services that really told us what our father's situation was and what our father needed. And yes, we then did use adult day care, but the cruel rules of eligibility made our family ineligible for any assistance. But we had the wherewithal to take care of that.

It was important for my father because it was Alzheimer's-targeted. I believe adult day care provided some respite for my mother three mornings a week, but it stretched out my father's cognitive ability, and we had our father with us longer and better than had we not had adult day care.

But we needed transportation to get Dad there. My sisters live in other parts of my community, and I had to come in and commute. Fortunately, there was a van that I had helped to get as a congresswoman that enabled Dad to get to those services that helped him and helped our family.

And then there came a time when it was cruel to keep our father at home. And we were not going to abandon our father, and we were not going to abandon our mother. That is when we turned to nursing home care and again saw that in order to face family responsibility, so many other families needing long-term care had to face family bankruptcy in order to qualify for Government assistance.

Well, we did not think that was the land of the free and the home of the brave. And at the same time, my mother, who has diabetic neuropathy, benefited from rehabilitation services so she is at home today, doing well, but during some bouts where she needed some additional assistance, we turned to Meals-on-Wheels. Meals-on-Wheels certainly helped us until we could get other intermediary steps.

I tell you this because I think we need to look at a broad picture. I congratulate President Clinton for his bold attempt on health insurance reform. But I think it is only the first step, and I do not think we should wait for health care reform to look at long-term care. What I think is that we need to look at a variety of things right now.

Mr. Torres-Gil, we are going to look at how we can change Title III and Title VII now, the kinds of services we have for geriatric evaluation and others, to keep people at home. What can we do in the Tax Code to give a deduction to families who are willing to help pay for the support? There are no "good guy" bonuses unless your family is dependent on you, but if you're willing to pitch in, as most families are, then you are out on your own.

What about a trust fund that Kate and Tom can set up for their son Rob, looking ahead over the years as he gets bigger, and they get older? I am sure you fear those situations.

And to Bill, who faced the cruel rules of Government where hard work was punished rather than rewarded.

And to Mrs. Reed, who has devoted her life to caring for others, and now gets no support and help as she cares for her own family.

I think we need to look at what we have got going for us now. Title III, Title VII. The Tax Code can be changed faster than we are going to reform health insurance. And what about bringing in national service participants to do chore services, to help guys like Bill, or maybe to spend some time with Rob, or maybe to help so Mrs. Reed will be able to do her shopping, or maybe to come in and help Mrs. Menkes? What about weekend Meals-on-Wheels?

So Mr. Chairman, I feel very strongly that we cannot wait for the Clinton health plan to pass, and that there are other tools now that with the same kind of creativity, ingenuity, innovation, dedication, and persistence that these families have, if Government acted the same way, then I think we could pool the services of the Government now and make a good first step, and I think we need to move in a quicker step.

So I feel very strongly about this. I did not intend to give a speech, but I will tell you this really goes right to my heart.

I do not know if the panel would like to comment on any of those things or what they think that they could use now, like a chore service from young people doing volunteer work in your own communities. Would that be of help to the Menkes and the Reeds, or perhaps to you, Bill, or the Miles?

Mrs. MENKES. Definitely. I think that is a great idea.

Senator MIKULSKI. What would you need?

Mrs. MENKES. Well, any help would be appreciated, and certainly, if it was a strong young fellow who could get him in and out of the shower easily, that is my major problem right now.

Of course, as you say, it is 36 hours a day, and it is just a long, long day, and it gets boring if nothing else, so you need the respite just to keep your own mind going and be able to come back refreshed and be able to take better care and more patient care because you have gotten a break yourself.

Mrs. REED. I would just like to say that I find it is best for me when I get up in the morning—I really cannot think about what is facing me for the day, and I just ask the Lord to give me patience—you sort of have to get your mind set that it is not a chore. If you think about it as being a chore or something that you do not want to be bothered with, it can do something to you. So you have to sort of put your mind that it is a joy doing, because otherwise, it would just be something that would upset the mind.

Now, the only other thing that really helps me is that we have been in the same church since I was 8 years old, so that is 52 years. Without the support of the church and friends—for instance, my girlfriend called me yesterday and she said, “Would you like me to come over around 4 o’clock?” and I said, “Good. I need to pick up some things for Daddy, and I would appreciate it.” So she came, and I was able to leave.

So there are outside people who have helped, because basically, when they took away the 4 hours that I had for the person coming in to bathe my father and then they gave me 2 hours, and I asked them what about feeding him, I was told that, “Oh, no, in the morning when we come, that 2 hours includes half an hour travel time.” So then breakfast was out.

I do not know. I think it is a bad thing when you are told—even 2 hours would give me time to go to the bank because my father has things that he has to have taken care of, and then I have things to take care of, but for an hour and a half, you cannot even get to the store. So it is just sad.

The CHAIRMAN. I personally favor a benevolent dictatorship with Senator Mikulski as our leader. [Applause.]

Senator Wofford.

Senator WOFFORD. Senator Mikulski may recall that Bill Buckley, from the other side of the political aisle, in a book on national service a few years ago in a book called “Gratitude: Reflections on the Debt we Owe our Country,” proposed that all of national service should be focused on service to those with long-term care needs and to the elderly, and that this experience would itself be a tremendous education for a million young people in this country. I think we should review that book again.

I was worried for a moment when Senator Mikulski said she was going to “compose” herself, because part of what this problem needs is her lack of composure, is the dramatization, making vivid the need. Our chairman is also on occasion able to lose his composure and to help dramatize.

I had a chance in an election a couple of years ago to be the carrier of the proposition that long-term care has to be a part of universal health insurance, and you today are helping—by being in the limelight, you are helping to dramatize this issue.

And I want to thank you for being willing to be in the limelight and to be stars on this video, because I look at that screen, and I realize that that is how we know how children are dying in Soma-

lia; it is that screen that takes it into everyone's living room. That video is a major contribution. We need to take that all over the country, and we need to have it shown to a mass audience, because I would say the problem of our Nation, focused right now on the health care issue, the problem of our Nation is that we see the natural disasters of fire raging in California, or a flood on the Susquehanna in Pennsylvania, and we see the challenge of overseas military problems and contests. But the unnatural human disaster of not responding to the most vital needs of our people, we do not seem to find a way to make vivid and to get the same sense of urgency and rallying together. And we have to do this, and this is an historic opportunity now to get universal health insurance. We have to make it vivid. You are playing a major role right today, even more than this hearing, I think, that video, in helping us to do it.

If you have any thoughts for us on how we communicate this, how we make it vivid, any coaching you have for us or any words for the American people on this, I would love to hear anything more you have to say. But I will dedicate myself to figuring out how we can carry this torch, but make it a very bright torch so that it wakes people up.

Bill Smith.

Mr. SMITH. I would like to say something. The system could make it more readily available and easier to find information. I found that it has been more stress for me just trying to find out how to get information about getting the help. Everyone I have talked to, nobody knows anything. It is more stress just trying to find the help.

My mother has written a journal which is probably 15 pages long on all the trouble that she has gone through. The system makes it so hard to find help that you do not even want to bother with it. It is easier to not even deal with the system than to have to go through all the headaches that they put you through.

Senator WOFFORD. That is a very important point. That even with the help that exists, finding information and knowing about it and getting through the red tape must be a terrible maze at the moment.

I would hope that out of this, with a universal system and a universal set of comprehensive benefits, there will be more clarity, as the chairman says, not just about what it costs, but clarity as to what we do. We will try to keep that in mind, Mr. Smith, as we go ahead, in terms of the information factor.

Mrs. MILES. I wanted to bring up a point as well. We are a family, and Robert is not our only child. We have a daughter, Kimberly, who is sitting over there.

Senator WOFFORD. Hi, Kimberly.

The CHAIRMAN. Do you want to stand up, Kimberly? We are very glad to have you here.

Senator MIKULSKI. Hi. How are you?

Senator WOFFORD. You are a star, too.

The CHAIRMAN. That is right. Thank you very much, Kimberly.

Senator MIKULSKI. And whom are you sitting with, Kimberly?

Miss MILES. My grandmother.

Senator MIKULSKI. I thought there was a resemblance there. Hello.

The CHAIRMAN. We are glad to have you both.

Mrs. MILES. Kimberly has had to endure so many sacrifices because of this. She goes back to school after summer vacation, and the kids talk about where they went for summer vacation and things they do all the time, and Kimmy is always asking, Mom, can we do this, or can we do that, and I have to say, "Sorry, Kim; we have Rob." There are places that we cannot take Rob and things that we cannot do, so she has had to make many sacrifices because there is no respite, nobody to come and give us a break so we can go out as a family.

We cannot have a 16-year-old high school girl come and babysit for Rob, for the same reasons that it is difficult for me to take care of him.

Senator WOFFORD. Thanks. That's a good point.

The CHAIRMAN. That is an enormously important point that we again do not give enough attention to.

And Bill Smith, that is an excellent observation. I just want the record to show I was looking out over the audience, and half or three-quarters of them were all nodding in agreement with the observation you made about the difficulty of getting information and the need for "one-stop shopping." We certainly want to do that and we are going to make sure we get that done to the extent that it is possible. Thank you for the excellent suggestion.

I will now recognize Tom Harkin, who has done so much for the disability movement in terms of legislation and support, giving a clarion call to the country. All of us welcome his leadership, and I will recognize him now.

Senator HARKIN. Mr. Chairman, thank you for those kind words, and again I thank you for your leadership in guiding and directive this committee and making sure that we got the necessary legislation through to get the Americans With Disabilities Act finally passed, and subsequent legislation to enhance it and make sure we are getting the proper rules and regulations developed to implement it.

I apologize for being late. This is one area of the health care program in which I am probably the most intensely interested, and I found myself unable to get here before now.

I would like to have my statement made part of the record, Mr. Chairman, and just say that I am delighted that the health care proposal by President Clinton does include long-term care and home and community-based care, and the fact that it is consumer-directed and consumer-driven. That is what it has got to be. It is about time we got rid of the idea that people in the bureaucracy know what is best, and they force a one-size-fits-all kind of thing.

But the one thing I want focus on and that I have talked at great length with Mrs. Clinton about is the whole area of personal assistance services. If we have home and community-based care, that is good; long-term care, that is good; consumer-directed and driven, fine—but if we do not look at the whole area of personal assistance services and what is included in that, that is really the next step. As I said, after the ADA gets signed, the next big hurdle is personal assistance services to enable people with disabilities to get

into the work force—and not only the work force, but just to get into the social life of our country.

People say that is going to cost a lot of money, but again, I believe the costs will be far outweighed by the benefits we will get from the fact that people will be able to work and to accomplish things. I think that will more than make up for whatever costs we will incur in personal assistance services.

Having said all that—and maybe this has all been covered before, and if it has, in terms of personal assistance services, I apologize—but I guess, Bill, what I would ask you or anyone else here is to take your own case. What types of services would you require that would enable you to get back into the work force and do your thing? What kind of personal assistance services would you need?

Mr. SMITH. To start with, transportation needs. I would need to be able to get back and forth, be equipped with a van and taught how to drive again. I would need to have an aide come in and help me in the morning and evenings with breakfast and dinner, and with showers. I would like to be able to get an education and get back into the work force. I would need help finding employment, pretty much anything just to get me back to where I could be more independent.

The areas where I cannot be independent are where I would need the aide to help me to stay as independent as I can.

Senator HARKIN. Is there anyone else here that I could ask about the personal assistance services? Is there anybody else at the table who could enlighten me as to what we should be looking at in terms of personal assistance services?

Mrs. REED. The only thing I would say is that I do not know what you are supposed to do for Saturdays and Sundays. You know, you get a little bit from Monday through Friday, but you get nothing for Saturday and Sunday. I am just fortunate that our church has a van, and I can have someone in—I cannot pay them what they are worth, but I have someone come in on my own on Saturdays and sometimes on Sundays, so that he is able to get out to go to church.

Senator HARKIN. OK. As we look at the long-term care portion of the health care bill, we are really going to have to look at personal assistance services as just an important integral part of it.

Again, I think people with disabilities want to be independent; they want to live at home; they want to get engaged in work activities to the best of their abilities. And people always focus on work, but I look upon it as more than just work; it is social activities, going to the theater, going to a restaurant—

Mrs. REED. Going bowling.

Senator HARKIN [continuing]. Going bowling, going to church on Sunday. It is the social life, also, that needs to be integrated.

Mrs. REED. Yes. It is gone. You cannot do that. Bowling is out of the picture.

Senator HARKIN. Yes, and I am saying that that ought to be a part of it, too.

Mrs. MENKES. It takes a great deal of effort to get the services. I mean, they are there, but it means a lot of phone calls. Sometimes, I think people would just rather not bother. They do not

have the energy to do that. I try to do it because I find it makes a big difference for me to get out and do other things.

Mr. SMITH. And like you say, it is a lot more than just having somebody take care of you at the house. I am 26 years old, and I have a lot more time left, and it is important to be able to get out and socialize and have a life other than just in the house or just at work.

Senator HARKIN. Yes. Again, I assure you that under the able leadership of our chairman, this is one area that we are really going to work hard on.

The CHAIRMAN. The personal assistance is one long-term care service that the Clinton plan mandates in every State. That is one absolute requirement, and we will have a chance to look closely at the language and examine it in great detail. But I do want you all to know that that is in there. We are going to try to require other services as well, but that is in there.

Senator HARKIN. I appreciate that. My concern is that States, in order to save up-front money, will say, "OK, we will provide personal assistance service—we will get you to work, and we will get you back," and that is the extent of personal assistance services. And I am saying that cannot be enough. It has got to be more than that. And I believe that it will be cost-effective, much more cost-effective in the long run, to provide those additional personal assistance services. That is my concern, Mr. Chairman.

Thank you.

[The prepared statement of Senator Harkin follows:]

PREPARED STATEMENT OF SENATOR HARKIN

Thank Senators Kennedy, Mikulski and Wofford for co-chairing this important hearing. President Clinton and his Administration are to be commended for recognizing that we have a problem with long-term care in this country and for attempting to address the problem in the bill that has been presented to Congress.

In speaking with people at a series of health forums I have held in Iowa and in reviewing the testimony of the witnesses, I was struck by four recurring themes.

The first is that the way we deliver long-term care services now to people in this country does not work. Many people who need the services cannot get them and those who are successful at getting the services are not very happy with the services they are receiving. Although most people would prefer to live at home with their families and in their communities, the great bulk of our long-term care dollars is going to institution-based care.

The Administration bill expands the funding for home and community-based care, and, as important, recognizes the importance of consumer involvement and consumer direction in the planning, implementation, and evaluation of the new system. These improvements will help to ensure that our new system will reflect the choices and preferences of its users.

The second theme is that our failure to address the long-term care needs of our citizens is costing us countless dollars in lost human potential. People with disabilities are being forced to stay at home or in institutions and stay poor in order to maintain services, and family members of aging and disabled relatives are rou-

tinely forced out of the work force in order to be a full-time caretaker.

By recognizing the central role of personal assistance services in the new home and community-based program, the Administration bill takes an important step in making it possible for people with disabilities to work and otherwise to participate in the mainstream activities of their communities.

Some say that we cannot afford to provide for long-term care as part of our health reform efforts. I would argue that we can't afford not to address the long-term care crisis that we as a nation face and will continue to face.

The third theme is that terms like universal coverage and health security will have little meaning for many of our citizens if long-term care services are not a part of our health delivery system. If you use a wheelchair and do not have the services you need to get out of bed and get dressed, your hypothetical access to a physician won't mean anything.

The fourth and final theme is that people want to have meaningful choices that will allow them to live at home in their communities. For these choices to be meaningful, the system that emerges from our health reform efforts must be flexible and provide a broad range of options that can address the individual circumstances of each consumer of long-term care. A child with uncontrolled seizures and severe mental retardation may have a different set of needs than a 60-year-old with Alzheimer's disease, and the system needs to be flexible enough to meet both their needs.

Once again, I commend the Administration for taking this important first step at addressing the long-term care crisis in this country, and I pledge to work hard with all the people who have been failed by the current system to clarify and refine the President's proposal and make sure that we take advantage of this opportunity to make a meaningful and lasting change for the better in the way we meet the long-term care needs of our citizens.

The CHAIRMAN. OK. We thank all of you very, very much for being here and for your willingness to share your experiences with all of us here on the committee. You are very powerful advocates, and you make a very powerful case. I just wish all the Senate had been here today, and that we could have passed the long term care legislation.

We will take a 3-minute recess.

[Short recess.]

The CHAIRMAN. We will come to order.

We have a full agenda, and we thank all of our guests for their attention and courtesy.

We are pleased to welcome our first assistant secretary for aging, Dr. Fernando Torres-Gil. Dr. Torres-Gil has a long record of distinguished scholarship on issues affecting the elderly, including long-term care. He is also a former congressional staffer, serving as staff director of the House Select Committee on Aging. He has also been an active board member for a number of groups representing the interests of health care consumers.

We are glad to have you here today.

STATEMENT OF HON. FERNANDO TORRES-GIL, ASSISTANT SECRETARY FOR AGING, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY MARY HARAHAAN, DIRECTOR, DIVISION OF LONG-TERM CARE, AGING, AND DISABILITY

Mr. TORRES-GIL. Thank you, Senator Kennedy and members of the committee.

It is a pleasure to be here, and certainly the film and the first panel have demonstrated why we are here and what it is that you all are attempting and what we are also planning with our Health Security Act.

I would like to introduce Mary Harahan, my colleague, who is the director of the division of long-term care, aging, and disability in the Department. As that title indicates, we see those three areas as interrelated.

I would like to commend this committee and this hearing for focusing on long-term care, and we will certainly speak to it, and I will submit my testimony for the record and just make some introductory comments.

As a gerontologist and a person with a disability, I certainly have a personal as well as a professional interest in these issues because, as this panel has indicated, we are all at risk, and at present there is very little that is available other than finding someone to help you pay for expensive care or impoverishing oneself in the Medicaid program. And the current system of long-term care can best be characterized as probably a "nonsystem" that is fragmented, with many gaps, and is institutionally-oriented.

We feel that the President's Health Security Act is taking a major step toward the type of long-term care system that these individuals here would like to have.

Our Act includes a package of long-term care reform that recognizes and embraces the diversity of the populations at need and at risk. It includes a major new expansion in home and community-based care services; it liberalizes the Medicaid nursing home requirements; it allows Medicaid home care to continue both as a safety valve for the low-income and severely disabled individuals. It also provides tax credits to help defray the costs of personal assistance services, and it establishes a series of regulations, consumer education, and tax incentive initiatives for private long-term care insurance.

Clearly, the centerpiece of the President's proposal for long-term care is this new home and community-based services program for which eligibility will be based not on income or age or type of disability, but rather on a person's functional or cognitive impairment.

There will be four mandatory eligibility criteria that will provide uniformity for this new system. One, those persons who need hands-on or standby assistance or cuing or supervision to perform three of five activities of daily living; second, persons with severe cognitive or mental impairment; third, persons with severe mental retardation, and last, children under 6 who have chronic disabilities and would otherwise require hospitalization or institutionalization.

The President's proposal in this area will benefit approximately 3.1 million persons. Approximately 71 percent will be over 65. But

it will also target substantial public funding toward these individuals with the most severe disability, thus freeing up States to use their other resources for assisting others with lesser levels of impairment under Medicaid and the State-funded programs.

It is a State-Federal partnership which will be generously funded. Our Federal matching will be approximately 28 percentage points higher than the current Medicaid match rate, with an upper limit set at 95 percent. In short, we will pay up to 95 cents on the dollar to support State efforts.

We feel that the incentives of this generous funding, the flexibility, as well as the basic Federal framework for finding eligibility, basic services, and consumer-oriented quality measures will in fact encourage States to adopt this new home and community-based program.

In addition, this program will guarantee that every person who receives services from this plan receives personal assistance services and is carefully assessed and has an individualized plan of care. In addition, to recognize diversity and flexibility in each State, we will require a menu or a range of benefits that States can choose from in providing services for home and community-based care. And it can range from case management to homemaker services to home modification to respite services, home-delivered meals, home health—the very services that were mentioned here earlier.

In addition, because we believe in the principles of independence and empowerment, we will allow States to offer consumer cash or vouchers instead of services so that those who want to take on the responsibility of controlling their own services can do so.

This program is a capped entitlement to States, which will be allocated according to a formula. It will include a sliding fee schedule for consumers to pay a portion of the costs, which will range from 10 percent of the cost for those at 150 percent of the poverty level to a maximum of 25 percent of the cost for those who are above 250 percent of the poverty level.

In addition, the funding for this program will be phased in over 7 years, beginning in 1996, and we estimate we will spend about 57 billion new dollars for this program during the first 5 years of the home and community-based program.

In addition to this centerpiece, there are other pieces which we feel will go a long way toward giving us the continuum and comprehensive set of long-term care services which were mentioned here earlier. Under the Medicaid program, we will enhance benefits by increasing the monthly personal allowance, and we will give the States the opportunity to increase the asset protection up to \$12,000.

In addition, for individuals such as Bill, who want to work, and find that the cost can outweigh the benefits, we will include a 50 percent tax credit for out-of-pocket expenditures on personal assistance and related services up to a maximum credit of \$7,500 a year.

Finally, we are also going to look to the private sector to play a major role to cover the high cost of nursing home care and other long-term care services. We are going to do a three-pronged approach to improving and strengthening the private long-term care insurance market.

And Mr. Chairman, I believe you will be pleased with the provisions in our plan concerning this private long-term care insurance. They are modelled upon those in your legislation, S. 2141, "The Long-Term Care Insurance Improvement and Accountability Act," which will include Federal standards for insurance; an advisory board at the Federal level to ensure that we are meeting consumer needs; a variety of requirements that will improve the products, improve the quality of these insurance plans, and provide safeguards to consumers; a set of tax provisions so that we treat private policies more like health insurance, where there are tax incentives for employers, where individuals can deduct part of the cost.

In summary, Mr. Chairman and members of the committee, we feel that we are taking a huge step forward in ultimately providing individuals and families with choices for how they want to be taken care of or how they wish to take care of loved ones, and we hope that you and members of the Congress will support our efforts to include these provisions in the plan.

Thank you very much.

[The prepared statement of Mr. Torres-Gil follows:]

PREPARED STATEMENT OF MR. TORRES-GIL

Mr. Chairman and Members of the Committee:

"What will happen to me, what will happen to my loved ones, if I need long-term care?" With the graying of the population, millions of Americans face this dilemma every day. These concerns, however, are not limited to the elderly. We are all at risk of becoming disabled at any age, and many younger people and their families currently struggle to meet their long-term care needs with little assistance from the public or private sectors.

To date, people who need long-term care have faced a unpleasant choice: make do with help from your relatives and friends, purchase expensive care on your own, or become impoverished enough to qualify for Medicaid. If you are able to get on the Medicaid rolls, you will have nursing home coverage, although that is no guarantee that a nursing home will accept you. And depending on the state in which you live, you may or may not receive home and community-based services. Long-term care in America today is, at best, a patchwork of financing and delivery systems, frequently piggybacking on programs that were not designed to deliver chronic care; at worst, it's not there at all when people need it.

The Health Security Act takes bold strides to weave the threads of patchwork into a comprehensive tapestry that makes sense for people when they face the dilemma of needing long term care. The plan respects the dignity of people who need support—it is not means-tested and does not discriminate by age. It honors the choices of individuals and their families. It offers public services and incentives to use private insurance.

The Act includes a package of long-term care reforms that recognize and embrace the diversity of needs and desires of people with disabilities. The focal point of this reform is a major new expansion in home and community based care services; in addition, the plan liberalizes Medicaid nursing home requirements, allows Medicaid home care to continue both as a safety valve for low-income and severely disabled and as the program for those who are less disabled who would qualify for Medicaid; provides tax credits to help defray the costs of personal assistance services for working people with disabilities; and establishes regulation, consumer education and tax incentives for private long term care insurance.

WHY FIX LONG TERM CARE? WHAT'S BROKEN?

From the outset of health care reform deliberations, long-term care—providing people with the support they need to make it through the day—has been an important focus of discussion. And the long hours of discussion have been fruitful. The long-term care section of the Health Security Act includes a series of new initiatives to significantly expand public and private coverage of long term supports.

What kept the long term care problem on the table? First, the concern that there are many people of all ages with chronic disabilities, who lack the support services

they need to lead independent lives at home or in the least restrictive setting. With the graying of America, the problem becomes even more compelling.

Millions of families face the daily challenge of providing long-term care to their relatives, with virtually no help. Three fourths of all long-term care delivered to the elderly in this country is provided by informal caregivers—spouses, children, parents. Informal caregivers also provide the bulk of support to people with disabilities under age 65. Most of these caregivers are there because they want to care for their loved ones; they aren't looking to hire a replacement, but they need some reinforcement.

Yet another concern is that for most people, the only way to obtain public help with long-term care is to first spend everything they have—to make themselves poor, in order to qualify for the Medicaid program. Right now, Medicaid is the only game in town for financing public long-term care services. Perhaps the greatest irony is that most people express a preference for home and community-based care, yet the lion's share of Medicaid dollars is directed toward institutional care.

Those who have the resources and would like to insure against the catastrophic costs of long-term care face a confusing private market with policies that vary in quality and affordability. Consumers do not have the confidence that the benefits will be there when they need them.

Finally, people with disabilities, themselves, helped sustain the long-term care discussion. People who, despite their disabilities, want to live "regular lives" in communities across America. People who want to work, but face enormous disincentives to do so. For these people, their families, friends, and service providers, the Health Security Act offers hope and solutions.

MAJOR EXPANSION OF HOME AND COMMUNITY CARE

The centerpiece of the long-term care plan is a flexible new program of home and community-based services individualized services tailored to the unique needs of people with severe disabilities. Generally, eligibility is based on a person's functional or cognitive impairment, with no limits by income or age or type of disability. Because people of all ages are equally eligible, this program goes a long way toward eliminating much of the historical intergenerational portioning of the long-term care pie.

Who will be eligible? The goal was to define—across disability category and age lines—people with the most significant needs. The four mandatory eligibility categories include:

- people who need hands on or stand by assistance or cuing or supervision to perform three of five activities of daily living (eating, bathing, dressing, toileting, and transferring);
- people with severe cognitive or mental impairments;
- people with severe mental retardation; or
- children under six who have chronic disabilities and would otherwise require hospitalization or institutionalization—after age six, children's eligibility is measured using the other three criteria.

Based on these criteria, it is estimated that this program will serve approximately 3.1 million people; an estimated 2.2 million, approximately 71 percent, will be over age 65. By targeting substantial funding toward those with the most severe disabilities, this program should free up state resources to serve people with lesser levels of impairment under Medicaid and state-funded programs.

The new long term care program is a federal/state partnership, like Medicaid, but more generously funded. The federal share of funding is, on the average, 28 percentage points higher than current Medicaid match rates, with the upper limit set at 95%. In other words, the federal government will pay up to 95 cents on the dollar to support state efforts to help people with severe disabilities live dignified, independent lives in the community. We believe States will have significant incentives to participate in this program, which combines enriched funding, flexibility, and a basic federal framework defining eligibility, basic services, and consumer-oriented quality assurance.

This new Federal funding is expected to go a long way toward achieving much needed interstate equity in the availability and quality of home and community-based care. This program is structured to embrace and support many of the innovative approaches states have already developed in their home and community-based care programs. Many of these innovative approaches resulted from the development of the aging network in response to the Older Americans Act (OAA) mandate to develop comprehensive and coordinated home and community-based service delivery networks, coupled with the innovations made by the disability network. States and

area agencies on aging have consistently worked to develop programs which are responsive to the needs of individual citizens. This is an opportunity to enhance their efforts. For states that have not come as far, the goal of the new program is to help build and strengthen the infrastructure for responding creatively to citizens' home care needs from the ground up.

The new home and community program is a free standing program, not subject to Medicaid requirements, so states have the flexibility to design service packages that really meet consumers' needs. Each state must guarantee that every person who receives services has been carefully assessed and has an individualized plan of care. In addition, each participating state must offer personal assistance services (including assistance with activities of daily living) under the Health Security Act, although not every recipient may use these particular services. Moreover, the availability of personal assistance and all other services is limited by the amount of Federal resources under the national budget amount.

The only requirement beyond those basic services is that states include in their service menu a range of benefits that address the needs of each category of eligible individuals. Beyond that, states are encouraged to include whatever services can best accomplish this—case management, homemaker and chore services, home modifications, respite services, assistive technology, adult day services, habilitation, supported employment, home delivered meals, home health—whatever these severely disabled people need to lead successful lives at home or in community-based residential settings. In addition, the program allows states to offer consumers cash or vouchers instead of services, a real boon to those who want to take on the responsibility of controlling their own services; in the words of many disability advocates: "we are not cases and we don't want anyone to manage us."

The legislation establishes a national budget for the new home and community services program. There is no individual entitlement to services; rather, the program is a capped entitlement to States that will be allocated according to a formula. Our estimates of what it will cost to serve this population are sound and sufficient, because the national budget or "cap" was estimated as though all eligible individuals would receive services. There is also a sliding fee scale for consumers to pay a portion of the cost of services under this program, ranging from 10% of costs for those at 150% of the poverty level to 25% of costs for those above 250% of poverty.

The funding for this program will be phased in, incrementally, over seven years, starting in 1996. States are explicitly prohibited from phasing in the funding or allocating resources by income; that is, individuals must be served from day one without regard to income.

Over the first five years (1996-2000), the federal government plans to spend \$57 billion new dollars for this program. The exact funding levels for new Federal dollars are specified in the legislation; the program is not subject to the appropriations process, it is an entitlement to states. Yes, the funding is capped; but it is capped at a level that represents over four times more than we are spending today in the uncapped Medicaid program for home and community based care. In addition, States may continue to provide services through Medicaid.

Experts in the quality field have noted that one of the best ways to measure the quality of services is to ask the people receiving them. Are these the services you thought you would be getting? Are they meeting your needs? Are you satisfied? Therefore, in addition to requiring careful reviews of health and safety issues, this program relies heavily on consumer monitoring and consumer satisfaction surveys. In addition, consumer responsiveness, a hallmark of this program, is ensured by the requirement that an advisory board, consisting primarily of consumers and their representatives, be involved in all aspects of planning, implementing and evaluating this program in each state.

Mr. Chairman, with regard to quality, the plan would also have the states specify the roles of the Older Americans Act long-term care ombudsman program, and the Protection and Advocacy Agencies, in assuring quality and protecting the rights of individuals with disabilities. The OAA requires the ombudsman program—which exists in every state—to investigate complaints and protect the rights of residents of nursing homes and other long-term care facilities. Some states now require the ombudsman program to help clients of home and community-based care and other health care services. The Ombudsman role has proven to be very effective in nursing homes and we believe it is a model that with adequate support would play a vital role in protecting the rights and well-being of disabled persons receiving home and community based services.

Finally, the plan also includes a performance review—an interim and final report card so we can check up on how the new system is working, and identify areas for improvement. On a related note, there are provisions for a series of demonstrations studying various ways to integrate acute and long term care.

MEDICAID NURSING HOME LIBERALIZATIONS

In addition to this major expansion in home and community-based care outside of the welfare framework, the plan liberalizes Medicaid nursing home requirements. All states will be required to establish medically needy eligibility criteria—to take medical expenditures into account in determining financial eligibility for nursing home care. Also, the amount of income that nursing home and other institutionalized residents may keep for their personal needs will be raised, making a real difference in the dignity and quality of life of many residents. Finally, states will be allowed the option of increasing the level of assets that single residents may retain from \$2,000 up to \$12,000. Research indicates that this will help a large group of people hold onto a precious nest egg.

New work incentive tax credit

For a disabled person who wants to be gainfully employed, the costs required to achieve this goal, including the purchase of personal assistance services, home and vehicle modifications, and specialized equipment, may outweigh the benefits. Indeed, many people with disabilities throw up their hands and ask: "why work? It costs more to work than to stay home." What a terrible waste; an explicit vision in this plan is to help members of the community, including those with disabilities, to bring their talents and skills to the fore, to be productive, contributing members of their communities.

To accomplish this goal, the plan includes a 50% tax credit for out of pocket expenditures on personal assistance and related services, up to a maximum credit of \$7,500 per year. People with disabilities welcome this new incentive to work. This provision is also consistent with the employment provisions of the Americans with Disabilities Act.

IMPROVING PRIVATE LONG TERM CARE INSURANCE: REGULATION, CONSUMER EDUCATION, AND TAX INCENTIVES

As we complete the solution to the long term care puzzle, the final piece is a three-pronged approach to improving and strengthening the private long-term care insurance market. Mr. Chairman, I know you will be very pleased with the provisions in the plan concerning private long-term care insurance as they are modeled upon those in your legislation, S. 2141—the "Long Term Care Insurance Improvement and Accountability Act"—that came close to enactment in the 102nd Congress. First, the plan establishes federal standards for private long term care insurance, to be developed by the Department of Health and Human Services, in consultation with a long-term care insurance advisory board. The board will include national experts, including representatives of the National Association of Insurance Commissioners, which has developed model standards for long-term care insurance. States will implement and enforce these new national standards. Furthermore, to ensure that the federal standards are more than just "paper" regulations, we will provide funds through the Fraud and Abuse Trust Fund to the states for enforcement assistance.

We recognize, however, that regulating the market will not automatically help consumers understand or trust the products. So the plan will also provide grants to the states for consumer education.

In order to encourage the development of quality products that will meet the long-term care needs of the consumer when catastrophe strikes—not just at the time of purchase—federal standards will include such requirements as nonforfeiture of benefits in the event of a policy lapse; offer of inflation protection; limits on pre-existing condition exclusions; third party notification of pending policy lapse; and clearly defined services, benefit eligibility triggers, and expected premium increases. To enhance consumer protection, standards of business practices include, but are not limited to a requirement that insurers establish appeals processes; independent evaluations for benefit eligibility; training and certification of agents and limits on their commissions; and prohibitions against improper sales practices.

The plan also includes a set of tax provisions that will encourage more people to purchase private policies. In general, these provisions treat long term care insurance more like health insurance. Consumers will be allowed to exclude from taxable income the amounts they pay for services or as receive cash payments from qualified long term care policies. The cost of qualified policies may be included as an itemized medical expense deduction. To help catalyze the development of a group market—which is most likely to assure a successful market in the future—the plan also includes tax incentives for employers to begin providing long term care insurance.

CONCLUSION

Mr. Chairman, this package of benefits has been designed to meet the needs of a wide range of people with disabilities of all ages and economic status. When fully implemented, these reforms are expected to provide immediate assistance to about three million people with severe disabilities living in the community and two million residents of nursing homes and other institutions. They also will extend emotional and physical relief to millions of families who are providing the bulk of long-term care to their loved ones. In addition, the steps we are taking to improve the private long-term care insurance market will raise the confidence of all Americans that high quality policies are available and will pay off when the need arises.

The CHAIRMAN. Thank you very much.

As I understand, by the time this program is actually phased in over the next 7 years, you will actually double the amount of resources that will be available in terms of home care and nursing home care. Is that generally right?

Mr. TORRES-GIL. That is right. Our estimate and our plan is that by the time it is fully phased in—I believe in the year 2002 or 2003—we will have provided over four times the amount of public resources for long-term care in comparison to what we are now providing for the Medicaid program. So certainly, there will be much more public resources targeted toward those most in need.

The CHAIRMAN. We will follow 8-minute rounds for questioning by members.

Let me ask a few questions about the spend-down provisions. We considered this during the Pepper Commission in terms of whether we have to require people to spend down to impoverishment. As I understand it, that issue is really not addressed in the administration's program. Am I correct?

Mr. TORRES-GIL. We begin to address it, Senator Kennedy, by giving States the option of increasing asset protection from \$2,000 up to \$12,000. We feel that is an important first step in that direction.

I might also mention that we give a big role to private long-term care insurance which, when it is following all of our standards and safeguards, we feel will also assist many more individuals to protect themselves against the high cost or catastrophic cost of nursing home care. So we feel we are addressing it in those two ways. It may not be as much as we want immediately, but we are moving in that direction.

The CHAIRMAN. It is a tough issue. People today are having difficulty in earning a dollar, and we are going to tax them to pay for services for other people who have assets. On the other hand, people have worked their whole lives to put a nest egg away, and we are forcing them into bankruptcy in order to qualify for help. So I have heard both sides of it argued very, very eloquently, and it is a tough public policy issue, and as I understand, you are at least taking some steps in that area.

Now, in the long-term home and community based care proposal you are mandating that every State has to have personal assistance, but you do not require adult day care, meal preparation, or chore services. How do you make a decision to include only personal assistance services but that we should not include the others?

Mr. TORRES-GIL. Well, Senator, we felt that to begin this program and to build upon the great efforts and progress that many States have made in diverse ways that we should begin this pro-

gram by requiring first the essential core of what should be a home and community-based system, after which States should have the discretion and the prerogative to come up with a menu of services.

We feel, as Senator Harkin mentioned earlier, that that essential core should be personal assistance services broadly defined to include assistance in those five ADL areas and that there should be a care plan. States will also have to monitor and provide us with the exact information as to what they are doing. That at least is a minimum to begin with.

After that, we want to really rely on State discretion and experience, from States such as Massachusetts that have gone a long way, and thus can provide a full range of services, and we can meet the diversity in those particular States.

So I guess we do not see it as an "either/or," but an essential core upon which they can then begin to pick from a variety of services.

The CHAIRMAN. Well, if this is the reason, then why do you put the restriction of three ADLs? Why not give greater flexibility to the States, following that same rationale?

Mr. TORRES-GIL. I think you have raised an important point there, Senator Kennedy. We realize that we cannot build a complete system overnight, so we deliberately want to target those who are most in need, and certainly those who qualify for three ADLs are most in need.

In addition, since this is a capped program, and the cost of it is based on the estimates of those who will qualify based on the four categories that I mentioned, we wanted to assure that there is at least uniformity in terms of the depth of services so we do not have a program that is spread thinly.

But I might also add that this is in addition to the other programs that now provide services to individuals who may not meet three ADLs. The social services block grant, programs under The Older Americans Act, and the Medicaid home and community-based waivers can also add to that.

Mary, would you like to add to that?

Ms. HARAHAH. As someone who has worked at the staff level in the Department for 15 years, I believe this is the first time the administration has come before the Congress with a long-term care bill, a long-term care bill that over the first 5 years will produce 57 billion new dollars in money. I think we made a decision from our perspective that it was best, given that resources were going to be limited in some way, to focus on people who are most severely in need and to adequately fund the program. But I think the Congress has a choice, and the choice is to expand eligibility, because there will be lots of people who want to do that. The result may be that there will be fewer benefits for everybody, and I think that is a very real choice that everyone faces in this bill.

The CHAIRMAN. Which brings us to the fact that with a capped entitlement, are you going to have enough resources to even cover all people with three ADLs? What happens in the situation where costs exceed the cap?

Mr. TORRES-GIL. I might first say, Senator, that we think the cap is fairly generous. As I mentioned, it is going to give us four times as much public resources as we may have had. And we think the States have had a good experience managing their existing home

and community-based programs. So we certainly hope that States will manage these dollars well, and we think they will go far; but it is true, at some point, they have got to watch them carefully because there are caps.

Mary.

Ms. HARAHAH. We do need to remind the Senators that this program has become known as "the three ADL program," but in fact that is not so. It is a program that is designed to bring in people who are severely disabled. They may be physically disabled, they may be cognitively impaired, they may be able to conduct their activities of daily living themselves, as some members of the earlier panel you saw could, if someone helped them. So all of those kinds of people will be eligible, not just people who are physically unable to conduct basic activities.

The CHAIRMAN. Well, we will obviously have an opportunity to examine this further with you. As you point out, this is the beginning of a long process, and we welcome the down payment on this important issue. I think we want to try to fashion and shape this in ways which will meet some of the needs of the first panel.

My time is expiring, but finally, one of the real concerns that people have is about ensuring quality in nursing home situations. How are you going to be able to ensure quality in the delivery of home care?

Mr. TORRES-GIL. We are absolutely concerned about quality. We know the sad history of nursing homes and boarding care facilities. So in the plan, we have a number of important strategies for addressing high quality.

First, every State will be required to set up an advisory board, the majority of whom must be potential consumers and their representatives. These boards will work with the States at all aspects of planning, implementing, and program monitoring.

In addition, there will also be a parallel Federal advisory board; again, the majority will be consumers and their reps, who will also assist us in quality.

This is going to be a consumer-driven organization, not an agency or necessarily provider-driven, so that consumers will be our best judge as to whether they are getting the types of services they want.

We will also require that each State spell out their quality assurance plan before their plan is approved, including the standards and staffing competencies.

Finally—and this gets to a point Senator Mikulski made earlier—this long-term care plan will be required to coordinate with The Older Americans Act. As you know, Title VII in fact provides an important new area for protection, advocacy, and ombudsman services which are required to be involved not just in nursing home, but home and community-based services. So we feel we are addressing this issue and learning from the last 20, 30 years of experiences, and it is certainly uppermost in our minds.

The CHAIRMAN. Finally, I hope you will keep in mind that the private long-term care insurance pays only 2 percent of the cost of nursing home care. We had legislation to make sure that it met certain criteria and requirements, but that really does not do an awful lot for a lot of people. I believe you said you will encourage

private insurance that people can buy to protect their assets. But how realistic that is in terms of meeting people's real needs is something we are going to have to take a good look at.

Mr. TORRES-GIL. If I may just mention, Senator, we have a series of safeguards to both regulate the market, educate consumers, and provide tax incentives. We estimate that by the year 2000 with our plan, up to 10 million persons will have private long-term care insurance as opposed to 2 million today. Now, granted that is not everyone who needs our services, but we think it is a substantial segment of the American public, so we feel that will play a significant role.

The CHAIRMAN. You know the history on this. As few as 2% of those who buy these policies ever actually receive benefits. It is a limited program, and I know we are attempting to deal with some of the immediate problems, but it is still going to be a real challenge to think that we can fill in the gap with private long term care insurance.

Mr. TORRES-GIL. Certainly.

The CHAIRMAN. We will have many other opportunities to talk about it.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, let me begin with just an observation. My time is expiring as well; I have got 12 months left on this side of the table. But I want to say to you and to your sister, Mr. Chairman, and to others I know in this room that I will be back on the other side of the table to deal with this issue.

Politically, long-term care was an issue before the uninsured became an issue.

Mr. TORRES-GIL. That is true.

Senator DURENBERGER. And as our friend Senator Wofford reminded us, it was swept aside because the politics of the 36 million uninsured seemed to represent a lot more people than the so-called politics of the people with long-term care needs. I am pleased that this hearing, hopefully, will elevate the significance and the importance of this issue. I believe this is a more serious problem, and it has more potential for solution than some of the other issues that are being featured right now—like the argument we got into yesterday of whether it is 36 million or 38 million uninsured, and whether it is going up by 50,000 or 200,000. I just think there is a greater opportunity here, and I thank you for concentrating on it, Mr. Chairman.

Second, I need to ask a question about where the administration is going in this regard. As I look through your statement, Mr. Torres-Gil, and as I reflect on the opportunities that we have, I see a very serious, well-intentioned effort to improve on what we have done before. I see a lot of concentration on what works and so forth. But I still see a whole lot of Federal programs—a Federal system by which the States and localities and private industry are going to try to take advantage of. And I know you may think we are moving away from this when we get into issues like quality.

Bless those of us who passed that 1988 Act, but Federal quality is costing people money in Minnesota; and it is not adding a whole lot of quality to nursing home care. I do not say this disparagingly. It is a way to lay a groundwork for something I said earlier, which

is that these opportunities can best be seized by us, health care consumers right where the family and the individual is experiencing the problem.

So I would have thought it might be a more appropriate challenge to this administration to say we are going to reform this health care delivery system, we are going to go to accountable health plans and health alliances and get consumers better-informed and more involved, and we are going to finance it by redesigning the partnership that we currently have between the Federal and State Governments.

If I could just concentrate on this area a little bit, let us talk about Medicaid. The cost of the Medicaid program has risen 25 percent in each of the fiscal years 1991 and 1992. That is the Federal contribution to the State level. About half of that money is going into nursing homes.

If in fact we want to deal with the problems of access to doctors and hospitals for low-income persons—not just the AFDC-connected—then we ought to federalize the subsidy for these people. That will save the States in this country a large amount of money—\$40 to \$50 billion a year.

Would this not be an opportunity to take the existing long-term care money and put it into the form of a block grant and challenge the States? You could use the eligibility criteria that you are using in your proposal, or the ones that the chairman is trying to get the OTA to improve on and so forth. But challenge the States and the local communities. Without telling them exactly how to do that, let them take on more of the responsibility for providing a wider variety of services for the people in their communities.

I suggested earlier that in my State and I think probably in some others, we might use these accountable health plans to do that, so that where you buy your doctors and your hospitals, you can also buy access to the system. It could be funded through a combination of insurance or private contributions or the Federal subsidy.

Would this not be a good opportunity, while the administration is so committed to providing leadership in health care reform, to take the Medicaid program and to say there are some parts of it that are more appropriately a national responsibility and other parts, which we now know from practice, that are better taken care of closer to home?

Mr. TORRES-GIL. I think I would say, Senator Durenberger, that you have raised some intriguing and important points. I think we are attempting to meet some of the issues that you are raising, which is really kind of a balance or a mix, so to speak, of approaches.

What we have here does several things. One, it does provide Federal oversight and monitoring, but without a huge new Federal bureaucracy. Second, it relies on States and communities and individuals to best determine what they need, and that is flexibility in the State programs. And third, it provides a role for the private sector in terms of private long-term care insurance, and certainly not to discount the merits in any publicly supported type of insurance program.

So I believe we try to respond to the need for diversity in different approaches. Incidentally, I was in Minnesota not too long

ago, and I visited a number of programs and met with the individuals from the Living at Home Block Nurse Program. It really demonstrated, Senator, what I think you are getting at, that they know best in a number of ways what is good and appropriate for them.

We are certainly looking carefully at that program, and at the Administration on Aging, we are also reviewing it for potential replication. So we are trying to be responsive, I believe, to the issues, and the specific approach we have is intended to provide a balance and a diversity of approaches.

Senator DURENBERGER. I really appreciate that, but the problem with trying to mix all of this—and the other problem you have is that you do not want to create an entitlement program because now entitlements are bad things. You do not want to create an entitlement program, so you are going to have a capped appropriation program of one kind or another. And the States out there, which you want to be more creative, are going to have an unpredictable flow of money because somebody is going to come through here and say, “wait a minute—we are putting all our money this year into acute care, because we are drawing down on that supply, and we only have a limited amount to go to long-term care.”

I am just suggesting to you that this is an area that, as we approach the whole issue of health care reform, would benefit from moving in the direction of more localized decisionmaking and more consumer involvement. We need to look at all of our opportunities. What about giving vouchered amounts to people, or through the States? By letting our communities take on the responsibility of figuring out what type of services and service delivery would work best for them, we could actually finance long-term care services through some part of the social insurance system.

Mr. TORRES-GIL. I thank you for that suggestion. We will certainly continue to look at that. I do not know if my colleague wanted to add anything to your very good point.

Ms. HARAHAH. I think one of the considerations that went into the home and community-based services proposal was the belief on our part and on many people's parts that while many States have developed very powerful, very sophisticated home and community-based service systems, that other States have lacked the fiscal capacity to do that, and that one of the things we wanted to do in this proposal was to balance—let us put the decisionmaking, the flexibility, at the local level, and that is why this plan leaves so many decisions to State and local areas, with putting the resources there so that there is a floor across all the States to provide access to people with the most severe disabilities. That floor is not there under the current Medicaid program because of the very different fiscal investment and fiscal capacity of States. That is why we have had such a high match rate.

The alternative is to continue the Medicaid approach, which creates these enormous inequities across States in terms of access.

Senator DURENBERGER. Well, I would like to explore this with you some other time. And I have been here long enough to hear that response. When you are talking about a national program, we always hear about States like Mississippi. But trying to apply a Mississippi standard in Minnesota is wasting an awful lot of money both for Mississippi and for Minnesota. If there is a way to deal

with this problem in a more comprehensive way so that we use these dollars more wisely, I would like to volunteer my services to try to be more helpful.

Mr. TORRES-GIL. Thank you, Senator.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

Senator WOFFORD [presiding]. Senator Mikulski. Senator Kennedy has asked me to chair, because he had an obligation elsewhere—and you do, too, shortly.

Senator MIKULSKI. Thank you.

I am one of the featured speakers at a lunch honoring the nurses who served in Vietnam, on the eve of the installation of their memorial, Mr. Chairman, so I will be going over to that lunch with those gallant and brave women.

And also, for the other witnesses, I will read your testimony and look forward to working with you on this long-term care issue.

I want to welcome you, Dr. Torres-Gil, another social worker, as well as you, Dr. Mary Harahan, who has really labored long in this field.

I, of course, support President Clinton's bold initiative in proposing this framework so that we could have a serious and sensible conversation on long-term care.

One of the key things, though, presuming the Clinton plan passes, presuming it works and is funded the way everybody would like it, and all concerns are addressed, it seems to me that the real hallmark will then be who defines "appropriate care" and who is going to do that definition on a case-by-case basis.

So I am going to get right to it in terms of one social worker talking to another. Throughout our population now are families like we heard testify that could be magnified time and time again. And I am concerned that primary caregivers, not the families, but primary care physicians, are not oriented and sensitive to being able to do the inventory of what appropriate care is and that geriatric evaluation services funded under The Older Americans Act are uneven.

I would therefore like to hone in onto who is going to do the geriatric evaluation and what plans the administration has in that area.

Mr. TORRES-GIL. Thank you, Senator Mikulski. You are right. I think you have gotten to the whole basis of how we really determine at the local and community level who receives what and in what way and under what conditions—and that is the whole issue of assessment.

We are requiring some uniform standards in terms of how eligibility will be determined for participants in this program, but as to how you assess it, how you get to that, we want to leave that to the States to determine the specific approaches and the specific assessment procedures.

We are requiring as part of the approval of their State care plan that we have that information and that we can monitor it and oversee it, but I guess we want to give the States a chance to use their discretion and their experience in this area.

I might just add, before I ask my colleague to add to that, that one of the other issues that relates to this is we want to assure

that it is also socially oriented, that in fact it draws in those providers that are really oriented toward care and compassion, that it is not an industry necessary, that it is not overmedicalized, that the social components are in place, which is one reason we are keeping it apart at the moment from the acute care side.

Mary, perhaps you would like to answer that.

Senator MIKULSKI. But before you answer, let me get to the quick of my concern. As I look even within my own State of Maryland, I find that the definition of "geriatric evaluation" is unclear. It is unclear, and it is uneven. So that, for example, in the city of Baltimore, we would have available for geriatric evaluation the geriatric evaluation center at the Johns Hopkins Francis Scott Key Program where, for a modest fee, you get a complete physical, a complete psychological, and a complete neurological, as well as a complete social family assessment as to what are the authentic and sustainable resources within the home.

When you go maybe just a few miles away, into another county, they have an information and referral service. You might go to a primary care physician who says, "I know Mr. Smithfield is a little slow, but keep him comfortable, and keep him at home." When the unusual behavior begins, like in Alzheimer's, often the confusion of time and day, then usually the choice is to put them on tranquilizers, and then put the spouse on tranquilizers. There is no sensitivity, really—and I say that in a no-fault way—as to appropriate diagnosis and then appropriate assessment.

What do you intend to do to have clear criteria on what are geriatric evaluation services, and how are we going to provide this service?

Mr. TORRES-GIL. Good point.

Senator MIKULSKI. You see, in every county, to just say leave it to the States—I have seen what the States have got, and frankly, I am disappointed at their uneven nature. And they call themselves a geriatric evaluation, but many do not even come close to that.

Mr. TORRES-GIL. No. I think you have hit on some of the concerns and some of the real problems. I know we have been discussing this in-house, and Mary might want to add to it.

Ms. HARAHAH. We have defined and will continue to refine through a process of consensus with experts and with all kinds of consumers functional characteristics that go into the eligibility determination process. Those will be standardized and uniform across all the States. Many of the questions that you refer to as geriatric evaluation are those questions that relate to the functional capacity of people, and they will be uniform. But I think we decided that we were faced with a dilemma in terms of trying to standardize the administration of an assessment.

Senator MIKULSKI. But who will decide that?

Ms. HARAHAH. I think there are two responses to that. One, the bottom line is that the State has the option to decide how to administer the program. The State is required to set up a consumer group that will review the entire design of the program, will comment on that program, and if the program is not responsive to the consumer representatives on this panel, we will forward their divergence to Washington as part of the approval process of the plan.

We concluded that there is so much diversity in the way States administer programs, and there is so much diversity in terms of the population groups that will participate, that standardizing the administrative process is virtually impossible, that we need to leave flexibility to the States and local governments, local agencies, to make process decisions.

Senator MIKULSKI. I think this is presenting a very serious dilemma in this debate, and I will be candid. We are talking about spending \$57 billion more, and we want to make sure that we get our money's worth and that also family needs are appropriately addressed. I believe this is a very weak link or weak part in this discussion. I believe in State flexibility, I believe in State innovation, creativity, entrepreneurship, and also to the characteristics of the State. Senator Daschle has 600,000 people in South Dakota, and he has a particular type of culture involving also Native Americans and so on. Maryland has 5 million. We will not even get into California, with a far more diverse population, rural, urban, and suburban.

So I am not for a cookie cutter approach, but I truly believe that there have to be clear criteria on who is going to make that assessment about who gets what, the criteria you just outlined. There have to be very clear concepts on that, and there has to be some uniformity or some standards that they have to meet. If we just farm this out to some HMO, I do not believe it is going to work.

I believe that many primary care physicians who are dedicated and often stretched very thin cannot do the evaluation components that you have just talked about, including the social aspect. Where is it going to happen? Who is going to do it? How do we make sure that it is done right?

Those are the questions that I think we have to answer if we in effect are going to spend \$57 billion.

Mr. TORRES-GIL. I would just say, Senator, that we certainly agree on the questions and what we want to go to. I think this is an area where we can work very closely in the next couple of months as we look at this.

Senator MIKULSKI. Absolutely. This is the beginning conversation. And this is also—and please do not misunderstand me—a no-fault conversation. I think, thanks to the boldness of the Clinton administration, and appointments like Dr. Shalala and yourself, we can even have this conversation.

Mr. TORRES-GIL. Yes, and at least we know we speak the same language as we move toward some kind of a consensus.

Thank you.

Senator MIKULSKI. We look forward to further discussions.

As the chair of the subcommittee on aging, the geriatric evaluation will be one of the hallmarks of my participation in this debate.

Thank you.

Mr. TORRES-GIL. I might just add if I may, Senator, since you also chair aging and The Older Americans Act, we certainly want to draw from the experiences and successes of the aging network both in delivering services and assessment and see how that might assist persons with disabilities of all ages. We know that we have to also do some other adjustments, but I think we will have plenty of opportunities to work together—yourself, our staff, and HHS.

But thank you for raising that legitimate concern.

Senator WOFFORD. Thank you, Senator Mikulski.

Senator Mikulski has noted that this is the beginning of the conversation, but I have been advised that this also should be the end of the conversation for this panel. The beginning and the end go together. You are nearby, and we thank both of you, and we will be working very closely as we probe and probe and probe until we get this right.

This is an historic opportunity, and we are going to do it.

Thank you.

Mr. TORRES-GIL. Thank you, Senator Wofford and members of the committee, and thank you, Mary. We look forward to working with you.

Senator WOFFORD. Good. Thank you.

I would like to invite the third panel to come forward. They are: Paul McCarty, Beatrice Braun, Max Richtman, and Anthony Young.

Our third panel consists of aging and disability groups that are responding to the administration's plan for long-term care. As one who, in my bill with Senator Daschle, had hoped we would go even further toward long-term care becoming a fundamental right of every American, the big stride forward in the President's proposal is that the President's proposal is the only major congressional proposal that is a serious attempt to meet this vital long-term care need of persons with disabilities of all ages.

Paul McCarty is the chair of the public policy committee for the Alzheimer's Association, and he currently directs the Nevins Family of Services, a nonprofit agency in Methuen, MA. Senator Kennedy would have liked to have been here to particularly welcome you.

Dr. Beatrice Braun is a member of the National Legislative Council of the American Association of Retired Persons. We are delighted to have you here, Dr. Braun.

Max Richtman is the executive vice president of the National Committee to Preserve Social Security and Medicare. He previously served as staff director of both the Special Committee on Aging and the Select Committee on Indian Affairs. We welcome him back.

And Anthony Young is the director of residential and community support services at the National Association of Rehabilitation Facilities. He is testifying on his own personal experience as a disabled experience, on behalf of himself and the Consortium of Citizens with Disabilities.

Paul McCarty.

STATEMENTS OF PAUL McCARTY, CHAIR, PUBLIC POLICY COMMITTEE, ALZHEIMER'S ASSOCIATION, METHUEN, MA; DR. BEATRICE BRAUN, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, SPRING HILL, FL; ANTHONY YOUNG, CO-CHAIR, PERSONAL ASSISTANCE SERVICES TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES, WASHINGTON, DC; AND MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, WASHINGTON, DC

Mr. McCARTY. Thank you.

I am here today as chair of the public policy committee of the Alzheimer's Association, representing 4 million people who have Alzheimer's-type dementia and their families who care for them.

My great-grandmother died a victim of dementia, tied to her bed in a State mental hospital, because there was nowhere in the community she could receive services.

Today, as you said, I direct the Nevins Family of Services, which provides community care across generations, including adult day health care for men and women who have medical and cognitive impairments.

I want to reinforce what you have just seen and heard from the previous panels and what you can see by just looking around this room. Long-term care is not an aging issue. It is a family issue. Our message to you and to Congress is simple: Health care reform is not comprehensive, it will not provide universal coverage, and it will do almost nothing for people with Alzheimer's-type disease unless it includes long-term care.

Senator Kennedy was one of the first in Congress to understand this and to introduce long-term care legislation. Now President Clinton has joined us. The President's plan and Senator Wellstone's bill are the only reform proposals on this table today that offer families any real long-term care protection.

The President actually builds on models of long-term care that States have been working to develop for years. In Massachusetts, we have built a case management system of home and community care. At my day health care center, we have been able to serve hundreds of families because State funding has been available to help them meet the cost.

However, we have seen a steady erosion of these services. As a direct result of skyrocketing health care costs, over 15,000 persons have been cut out of our State-funded home and community care program over the past 4 years. The President's plan will make an enormous difference by finally bringing health care costs under control so State dollars will go further and by infusing the system with new funds for home and community care.

The Alzheimer's Association enthusiastically endorses the President's long-term care proposal. Among features of the proposal that we consider absolutely essential include that it is a program for persons of all ages and all incomes; that it includes persons with cognitive and mental impairments as well as physical disabilities. There are some issues that we raise in the written testimony. Let me identify just one.

The President lists a lot of services that may be included in the State plan, but the only service that must be included is personal assistance, and that is narrowly defined. We recommend the legislation require that States make available the entire array of authorized services so that individuals can receive the specific services that best meet their own plan of care.

Even with the best home and community care program, there will still be people who need nursing home care. The President would not do much to change the way we now pay for nursing home care. For most people, Medicaid will continue to be their only option, and they will have to spend themselves down close to poverty to qualify.

Senator Kennedy's proposal for a voluntary public insurance program can help fill that gap. This would let people purchase a reasonable amount of insurance at fair prices, without adding to the public cost. It is not the social insurance approach that we both would prefer in a more perfect world, but we think it is a much better way to provide protection than to rely on the private insurance market. We are trying to straighten out a health care system that has relied totally on a wide open private insurance market. Why start down that road with long-term care?

If the President's plan is enacted, millions of families dealing with chronic illness and disabilities will have the help they do not have today. Finally, we will include them into the big system.

The Alzheimer's Association is prepared to work with you to bring all of the advocacy resources in our network of 221 chapters to bear to make sure this happens.

Thank you for this opportunity. I will be happy to answer any questions.

Senator WOFFORD. Thank you. I appreciate your interest in the public voluntary insurance program. It has been a priority of mine for a long time, in the task force and in working with Senator Kennedy.

[The prepared statement of Mr. McCarty follows:]

PREPARED STATEMENT OF PAUL MCCARTY

Thank you, Mr. Chairman. I am here as Chair of the Public Policy Committee of the Alzheimer's Association, representing the interests of the 4 million people who have Alzheimer's disease and the families who care for them. I am the great-grandson of a woman who died a victim of dementia, tied to her bed in a state mental hospital because there was no place in the community where she could receive care. Today, I direct the Nevins Family of Services, a nonprofit agency in Methuen, Massachusetts which provides community care across generations, including adult day care for older women and men who have physical or cognitive impairments.

Long Term Care—A Family Issue

I want to begin by reinforcing what you have just seen and heard from the previous panel, what you can see by looking around this hearing room. Long term care is not an aging issue. It is a family issue. It affects people of every age. One third of all persons who need long term care are children and younger adults—like Rob Miles and Billy Smith. But regardless of the age of the person who needs care, as you saw in the film, every person in the family—parent, spouse, sibling, child, grandchild, even great-grandchild—is affected.

We have a health care system now that discriminates by disease and disability. If you have a heart attack and need surgery, or if you have cancer and need chemotherapy, the system recognizes your health care needs and insures them. But if your child has cerebral palsy, if you suffer a spinal cord injury, if you get Alzheimer's disease, the system ignores you because the type of health care you need—long term care—is not provided in hospitals or doctors' offices.

97% of American families are uninsured against the devastating cost of long term care.

Our message to you is simple: Health care reform is not comprehensive, it will not offer universal coverage, and it will do almost nothing for people with Alzheimer's disease, unless it includes long term care.

Mr. Chairman, you were one of the first in Congress to understand this and to introduce legislation to provide long term care. Now President Clinton has joined us. The President's plan and Senator Wellstone's bill are the only reform proposals on the table today that offer families any real long term care protection.

Home and Community Care in Massachusetts

The President builds on the models of long term care that states have been working to develop for years. In Massachusetts, we built a case managed system of home and community care, with a single point of entry that identifies individual needs and responds to them with a flexible array of services. At our day care center, we have been able to serve hundreds of families, because state and Medicaid funds helped meet the cost.

Tragically, we have seen a steady erosion of these programs in Massachusetts—as a direct result of skyrocketing health care costs. The same thing is happening across the country. Over 12,000 participants have been cut out of our Medicaid home and community care program. And 60 percent of those who once might have been served through the state's Home Care Corporations no longer have access to services.

The President's health care reform plan will make an enormous difference, first by finally bringing health care costs under control, so state dollars will go further. And second, by infusing the system with major new funding for home and community long term care. Finally, the state of Massachusetts may be able to stop robbing Peter to pay Paul, and all of a family's health care needs—including long term care—can be addressed.

The Clinton Plan for Long Term Care

The Alzheimer's Association enthusiastically endorses the President's long term care proposals. He is starting in exactly the right place—with home and community care. Everything in my experience with the Alzheimer's Association and at Nevins tells me this is exactly what families want and need. And the public opinion polls certainly bear that out.

We know we are at the beginning of a long legislative process and that changes will be made. But there are certain features of the President's long term care proposal that the Alzheimer's Association considers absolutely essential:

First, it is a program for persons of all ages and income, with protections for low-income families and cost-sharing for those who can afford to contribute.

Second, it includes specific eligibility language to assure coverage for persons with cognitive and mental impairments as well as physical disabilities.

Third, it provides consumer choice of services and providers, and allows consumers (or their families in the case of a person with Alzheimer's disease) to direct those services.

Fourth, it is flexible, so that services can meet individual needs, rather than a "one size fits all" program.

There are issues which we must address as we work through the legislative process. First, we must assure that people get the long term services they need. The President's proposal lists a broad array of services that may be included in the state's plan—including services like adult day care, respite, home modifications, and services in community residential settings which are very important for people with Alzheimer's disease. But the only service that must be included is personal assistance, narrowly defined. We recommend the legislation require that states make available the entire array of authorized services, so that individuals can receive the specific services that best meet their own plan of care.

Second, the President's plan does not require states to participate in the new program. We think the risk that states would actually opt out of the program is relatively small. With the favorable federal match in the plan, combined with the clear interest in home and community care in most states, we think most states will be knocking at the door. But you must provide some safety valve so that if a state does refuse to participate in the program, residents of that state may still get the services for which federal funding is available.

Third, there must be secure financing of this new benefit. We recognize that creating a new "open-ended entitlement" may not be possible right now. But the worst possible outcome of our current enterprise would be to enact legislation that turns out to be an empty promise because there is no money to implement the program.

We do not ignore the central concern Congress must have about cost. The President is proposing significant new expenditures for long term care. But there is mounting evidence that such expenditures will yield important savings, in nursing home costs and in avoidable hospital expenditures.

For example, Wisconsin has emphasized home and community services through its community options program, and has cut its Medicaid nursing home bed use by 19%, at the same time bed use was rising 24% nationally.

According to the National Institute of Medicine, delaying admissions to nursing homes by just one month would save \$3 billion a year. Wisconsin proves this is an achievable goal.

In the Independent Living for Seniors program in Rochester, New York, use of adult day care has cut hospital utilization by participants in half.

A study released this summer found that costs of paid care for persons with Alzheimer's disease in a nursing home are three and a half times more than the costs of paid care for a person living at home. That is because families continue their central role as caregivers when they get help, instead of turning the whole job over to paid providers.

The President proposes the right public-private partnership—a partnership with families.

Addressing the Costs of Nursing Home Care

President Clinton would turn the long term care system upside down. Instead of forcing people into nursing homes, he would give them the services and supports they need to stay in the community, to live productively, to hold families together. But even with the best home and community care, there will still be people for whom nursing home care is appropriate and necessary. That care will continue to be very expensive. And most people will not qualify for the skilled nursing benefit in their basic health care plan.

The President's plan would not do much to change the way we now pay for nursing home care. For most people, Medicaid still will be the only option. And they will have to spend themselves down close to poverty to qualify. (The President does make some changes in Medicaid eligibility rules, the most important of which is to require that every state establish a medically needy program for nursing home care. This will end the tragic situation in roughly 20 states that now set fixed income caps—leaving desperate people caught in the Medicaid gap, with too much income to meet Medicaid standards and too little to pay privately for care.)

For those few who can afford to purchase private long term care insurance, the President would establish uniform national standards to assure that people get what they pay for. But most people will be left still without any protection against the high cost of nursing home care.

Your proposal, Senator Kennedy, for a voluntary public insurance program can help fill the gap the President leaves in our current system of financing long term care. This would allow people to purchase a reasonable amount of insurance at fair prices, without adding to the public cost of the system. It is not the social insurance approach we would both prefer in a more perfect world, but we think it is a much better way to provide protection than to rely on the private insurance market. We are trying to straighten out a health care system that has relied totally on a wide open private insurance market. Why start down that road on long term care?

Mr. Chairman, it is easy for families who are dealing with Alzheimer's disease to support wholeheartedly the President's long term care recommendations. If the President's plan is enacted, they—like hundreds of other families dealing with chronic illnesses and disabilities—will have help they cannot get today. Finally, they will be part of the system.

The Alzheimer's Association is prepared to work with you, and to bring all of the advocacy resources in our network of 221 Chapters to bear, to make sure this happens. Thank you for this opportunity to testify. I will be happy to answer questions.

Senator WOFFORD. Dr. Braun.

Dr. BRAUN. Thank you, Senator.

I am Beatrice Braun, a member of AARP's National Legislative Council.

Before commenting specifically on the President's proposals for long-term care, I want to speak to an issue on all of our minds—cost. We know that many of you, and many here, have personal experience, friends or family who have had to cope with the financial

and emotional stress of being involved in meeting long-term care needs.

As policymakers, however, it is also natural to translate the subject into a vision of Federal budget dollar signs. But our families also see dollar signs. They see huge dollar signs when they struggle to pay for home care for a child, a spouse, or a parent, while still dealing with college tuition costs and a home mortgage.

Equally important is the cost that caregivers bear—daughters, spouses, and mothers—and in turn, the cost to our economy. We pay in lost wages, and the Government pays in lost tax revenue. We pay in lost or reduced pensions and in lower Social Security benefits. The Government and we as taxpayers also pay in high assistance costs later.

The President's proposal for a new home and community-based care program recognizes that few families can afford the cost of such care, and that the need may involve a child born with a developmental disability, an accident victim, or a parent with Alzheimer's disease. Appropriately, the proposal focuses eligibility on measures of disability, not age or income.

While we are still assessing the proposal, there are a number of areas that should be strengthened. For example, we are concerned that the President proposes an optional program for States which is funded by an annual or matching grant to the States rather than a direct payment to or on behalf of an individual. This raises several questions. What happens to those who need care in States reluctant to participate? Would funding be subject to annual appropriation and sequestration? Would the program require cutbacks in other appropriated programs? Could services to current recipients simply be cut off if the funds run out? Would they have to reapply the next year?

To improve the reliability of the program's funding within the proposed caps, changes in the intensity of service need and real wage growth should be reflected in budget estimates. Following the model established elsewhere in the proposal, an additional 15 percent cushion should be included as a margin of error, and any excess funds should be permitted to be carried forward and not charged toward the next year's cap.

With regard to the role of the States, we agree that there is merit in State administration of a home and community-based program, but State flexibility must be balanced with clear, enforceable Federal guidelines and oversight.

Although we are pleased to see even the small Medicaid nursing home coverage improvements, millions would remain vulnerable to bankruptcy due to expensive nursing home costs. Studies show that people's greatest fear is impoverishment from nursing home costs, which now average \$30,000 a year and can exceed \$60,000.

The Association supports the development of uniform Federal standards for private long-term care insurance policies and is particularly pleased with the President's proposed treatment of the inflation and nonforfeiture protection issues.

In the absence of a comprehensive nursing home proposal, incremental reforms such as the chairman's proposed Life Care Act merit serious consideration. The proposal would permit many persons to buy a policy who are now excluded due to health problems.

We are concerned, however, that private insurers might skim the healthiest purchasers and leave the worst risks to the public program. Subsidies should be considered to make policies more affordable.

In general, we must remember that while modifications to the President's long-term care proposal are needed, it is a vast improvement over our current nonsystem. The President has made a serious start toward achieving security against the overwhelming human cost of long-term care.

Since the proposal does not, however, meet the full extent of the need for long-term care, we should not attempt to oversell the proposal.

In conclusion, AARP commends the President and members on both sides of the aisle who have brought the debate to this stage. As we go forward, we ask you to always consider the cost to American families of not including long-term care in health care reform. Our job is to shape and improve the proposal so that it will begin to provide real security and protection now and a solid foundation for the future.

There is one thing we must all agree on: The status quo is not an acceptable option.

AARP looks forward to working with the members of the committee to ensure that long-term care remains an integral part of health care reform.

Thank you.

Senator WOFFORD. Thank you.

[The prepared statement of Dr. Braun follows:]

PREPARED STATEMENT OF BEATRICE BRAUN

Good Morning. My name is Beatrice Braun, and I am a member of the National Legislative Council of the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today as the Committee reviews one of the most critical problems facing families today: the need for long-term care.

Over the past several years we have listened closely to what our diverse membership and their families, as well as the American public, tell us they want in a health care system. Despite their differing circumstances, the vast majority of Americans, old and young, have consistently stressed the need for broader protections against the high costs of health and long-term care. Some assume that concern about and support for long-term care coverage is confined primarily to the older population, but, in fact, the 50-64 age group is even more worried, both for their parents and themselves.

AARP commends President Clinton for his bold and constructive plan for accomplishing reform. We also commend the First Lady, Congressional leaders in both parties, and this Committee for a commitment to addressing this issue now. The nation has waited too long for comprehensive reform. We must use this unique point in history to enact true reform which covers everyone, maintains high quality care, makes health care costs affordable, and includes coverage of both prescription drugs and long-term care.

The inclusion of long-term care is vital to our members and their families and is critical to AARP's support for any health care reform proposal. Unfortunately, many Americans still equate long-term care with nursing home care. Long-term care, however, is much more than just nursing home care. It includes a wide range of home and community-based care as well as residential alternatives.

AARP is pleased that the President's proposal includes coverage for home and community-based care for persons of all ages and incomes. Too many reform proposals focus only on acute care and simply ignore the long-term care needs of American families. These proposals are fundamentally flawed because they fail to address the need for a full continuum of care throughout an individual's life. Without long-term care coverage, no family has real security against the crippling costs of serious ill-

ness or disability. The President's proposal represents a serious start towards addressing the unmet long-term care needs of millions of American families.

Long-term care is typically considered a benefit for the elderly. This is a myth—the need for long-term care crosses generational lines. An estimated 10 million persons need some form of long-term care; approximately one-third of these individuals are under age 65. Many are children. Moreover, the need for long-term care is felt not just by those requiring care, but also by their families—often those providing and paying for care. This is particularly true in the case of those in the “sandwich generation,” caught between meeting the needs of their children and their parents.

Health Care Reform Must Include Long-Term Care

While approximately 37 million people lack basic medical insurance, virtually all Americans lack protection against long-term care expenses. To a family sitting around the kitchen table, there is no difference between spending \$20,000 on hospital care and spending \$20,000 on home care. It is still \$20,000 they do not have. Therefore, to achieve true security, savings, and quality in our health care system, care must not be limited to the provision of services by a hospital or doctor; long-term care must also be included.

The need for comprehensive services—it makes little sense to provide financial protection against the cost of an acute illness but leave people vulnerable if they suffer from a chronic and disabling condition, especially since the need for these services often is so interrelated. Results from research conducted on the Social Health Maintenance Organization (SHMO) demonstrations in the late 1980's illustrates why integrated care is so important—custodial and skilled services are often needed to complement one another. Almost 70 percent of initial referrals for community-based long-term care originated from hospitals and other parts of the medical care system. Moreover, 37 percent of the care plans developed for home and community care included concurrent authorization for medically necessary skilled services. In addition, individuals' level of disability frequently changed and was tied to acute episodes of illness. Without comprehensive benefits, patient care will not be effective, and costs “avoided” in long-term care may instead show up as costs in the acute care setting.

Families cannot afford long-term care—with average annual nursing home costs of \$30,000 (and some areas experiencing costs of \$60,000 or more) and home health care costing from \$50 to \$200 per day, long-term care out-of-pocket costs can often devastate a family. For most people, the cost of long-term care is an unmanageable financial burden. Many families are also shocked to find—only too late—that neither Medicare nor private insurance covers long-term care to any great extent.

Caregivers are being unfairly burdened—family members provide the vast majority of long-term care to persons of all ages. But caregivers place their own health in jeopardy and frequently are forced to leave the labor market, thereby suffering not only short-term loss of income, but also long-term reduction in Social Security and private pension benefits.

In a recent focus group, a woman in her 50's related her story:

Rose had held a good job with a large corporation until her mother needed long-term care. Unable and unwilling to place her mother in a nursing home, Rose quit her job—6 months before her pension would have vested—to care for her mother. She saw her future income potential and retirement security disappear as she made the painful decision to take care of her mother.

There are many stories just like this. They typically involve women in their 50's—primarily spouses and daughters—who sacrifice financially, physically, and emotionally to assure that a loved one is cared for. The Association believes that caregivers deserve strong support.

Private sector solutions cannot work—the private market has not and cannot provide adequate and affordable protection against the cost of long-term care. Private long-term care insurance that provides meaningful coverage is very expensive and generally excludes people with pre-existing conditions or mental disorders. Few people can afford the cost of private long-term care insurance for any length of time, particularly if the policy is of good quality. These policies have done a particularly poor job in trying to cover home care because insurance companies are not confident in their ability to control the risks and demand involved.

Public Support for Long-Term Care

Americans of all ages strongly support health care reform that includes coverage for long-term care. A survey conducted for AARP this past April found that 90 percent of the respondents felt that including long-term care in a health reform proposal was important. Support for health care reform increased from 46 percent to 82 percent when long-term care was included (See Attachments 1 and 2). More re-

cently, in a poll conducted for AARP in October, 86 percent of respondents in California stated that they would be less in favor of the President's health care proposal if it included no coverage for long-term care.

According to a survey conducted in the fall of 1991 by DYG, Inc., three-fourths of Americans (18 and older) were "very concerned" about paying for the cost of long-term care. The concern, which is felt sharply by both men and women, extends to all income and age groups. In fact, concern about long-term care was greatest among persons age 50-64—those most likely to be caring for older parents and worrying about their own futures (See Attachments 3-7).

In a Harris survey conducted during December 1992 and January 1993, 91 percent of the respondents said they could not afford long-term care when they were told it would cost \$15,000 to \$60,000 a year, or \$40 to \$160 a day. With regard to a federal program providing long-term care in the home for the chronically ill or disabled, over 80 percent of respondents favored such a program not only for people 65 years of age and older, but for adults and children as well.

AARP Views on Long-Term Care

To make long-term care coverage affordable and accessible to all Americans, the Association believes that the ideal solution is a social insurance program, similar to Medicare and Social Security, that would provide a comprehensive set of benefits in the home and community, as well as in nursing homes. A social insurance program would require financial contributions from all members of society and would provide protection to all who need long-term care, regardless of age or income. Such an approach would spread the risks so that the costs to any one person would be small, while offering protection and appropriate care to all. Under such a social insurance system, private sector initiatives would supplement the public system by covering coinsurance, deductibles, and additional needed services.

Other fundamental principles which underlie AARP's views on long-term care include: (1) provision of a comprehensive range of services, including institutional and home and community-based care; (2) financing which is equitable, broadly based, and affordable to all individuals; (3) coordination between the acute and long-term care systems to assure a continuum of care across an individual's lifetime; (4) assurance of high quality care; (5) effective cost containment mechanisms; and (6) support for informal caregivers.

These principles are at the foundation of AARP's proposal for comprehensive health care reform—"Health Care America." The proposal was developed with the extensive involvement of AARP members across the country. The long-term care provisions of the proposal include comprehensive coverage through a new Medicare-like program. Eligibility for a full range of home and community-based services would be based primarily upon dependencies in 2 of 5 Activities of Daily Living (ADLs). Nursing home protection, excluding coverage for room and board, would be available over the entire length of an individual's stay.

The President's Proposal for Home and Community-Based Care

The President's health care reform proposal is a serious start toward addressing the unmet long-term care needs of millions of American families. The proposal is a dramatic improvement over where we are now and provides sound footing on which more comprehensive approaches can be developed after the program is implemented.

We are also pleased that Senator Kassebaum's S. 325, the BasicCare Health Access and Cost Control Act, recognizes the need to provide for coverage against extraordinary long-term care costs. However, we urge that such protection also be required to be made available for older Americans. We commend Senator Wellstone for introducing S. 491, the American Health Security Act, which provides comprehensive long-term care, including nursing home coverage, for all in need. But this proposal includes a \$65 monthly premium, which persons over age 65 with incomes above 120 percent of poverty would have to pay. Such an expensive, "elderly-only" premium would clearly be unaffordable for most.

The Association believes that, given limited resources, the President is on the right track in basing eligibility for the new home and community-based program on levels of disability, rather than age or income. An eligibility assessment and determination based on level of disability, when combined with the proposed care plan, would begin to address the serious problems of fragmentation and unmet need that currently exist for disabled persons of all ages. Age is not a viable eligibility criterion because approximately one-third of persons with severe disabilities who need home and community-based care are under age 65. In addition, since the program is not based on a welfare model, those in need will not be forced to bankrupt themselves before getting help, as they must do now to be eligible for Medicaid.

The President's proposal for home and community-based care would provide much needed support to caregivers who are shouldering enormous burdens by taking care of their loved ones and often missing work to do so. Many caregivers perform these services out of a strong family commitment and a desire to postpone nursing home placement for as long as possible.

The President's home and community-based care proposal would begin to provide to disabled persons and their families real choices about how to arrange for and where to receive the most appropriate care. Today people are being forced into nursing homes prematurely or going without care because they do not have access to affordable home and community-based care. Historical patterns in public spending reflect a perverse bias, where approximately four out of five dollars spent on long-term care go to institutional care. This creates situations in which families are broken apart and Americans are denied care in the most appropriate setting, as well as where they would like to receive it. For the first time, under the proposal, many disabled Americans could receive services through the full continuum of care.

Suggestions to Strengthen the President's Home and Community-Based Care Proposal

At the same time the Association applauds the President for recognizing the need to expand coverage and options for home and community-based care, we have specific questions and concerns about the proposal. We look forward to working with the Administration and the Congress to strengthen the proposal.

We agree with the need to contain long-term care costs and to keep federal expenditures under control, given limited resources. Effective care management and appropriate provider reimbursement should help in this regard. However, certain elements of the proposal that are designed to reduce program costs and others relating to the role of the states raise particular concerns.

Proposals to minimize program costs

Caps on Funding—The proposal is, in effect, a matching grant program to the states. We have questions about how this would work.

Would funding be subject to annual appropriation or sequestration?

Would the program be included under the PAYGO provisions of the Budget Enforcement Act?

What would happen if the program ran out of money before the end of the fiscal year? Would services to persons currently receiving care simply be cut off?

Would a requirement for reassessments between fiscal years interrupt continuity of care?

The capped nature of the proposed program makes it all the more critical that the data and criteria used to estimate full funding over time are accurate and sufficiently inclusive. Otherwise, funding shortfalls could easily occur, resulting in potentially serious levels of unmet need. The baseline estimates, for example, must include accurate cost and utilization assumptions for all groups of eligible persons, including severely disabled children.

The adequacy of inflation and trending factors are a concern because they do not seem to account sufficiently for future changes in the intensity of service needs or real wage growth among workers in the very labor intensive home care area. The irregular funding pattern in Section 2109 of the President's legislative proposal increases the level of our concerns.

To help address these concerns, we recommend that the caps on funding for home and community-based care be accompanied by the same safeguards as caps on low-income subsidies for acute health care services. Specifically, an additional 15 percent cushion should be included as a margin of error, and any excess funds should be permitted to be carried forward and not be charged toward the next year's cap.

Phase-in Schedule—The proposed eight-year phase-in period will also be of concern to many of our members. Quite realistically, they will wonder how much of the benefit they will receive. The original proposal had a five year phase-in, while most other provisions in the President's plan have a three year phase-in.

Beneficiary Copayments—We recognize that beneficiaries must pay a meaningful coinsurance for this program; indeed our own Health Care America proposal included a 20 percent coinsurance. However, a 40 percent coinsurance is high compared to the copayments proposed in other parts of the President's health care reform package and could be prohibitively expensive for those with incomes just above 400 percent of poverty. It would appear that the jump from 20 or 25 percent coinsurance to 40 percent at these income levels produces only a small increase in offsetting receipts. In addition, virtually all eligible individuals would have to submit income data to receive services; creating a potential welfare stigma and increasing administrative burdens. It is our understanding that the 40 percent coinsurance

proposed may be due to a drafting error, and that the top amount would be 25 percent for persons with income up to 250 percent of poverty.

Definition of Disability—The Association is pleased that the proposal would cover persons who need stand-by assistance or cueing to perform 3 or more ADLs. However, we would ultimately like to see a 2 of 5 ADL standard.

Issues regarding the role of the states

Option for the States—It appears that states would have the option of not participating in the program at all. This could pose serious problems for consumers. Further, it is not clear what the states' financial obligation would be under the proposal. For example, poorer states, or those that do not fare well in the determination of state maintenance of effort, may elect not to establish a program or may postpone participation until much later in the very long phase-in schedule.

Variation and Fragmentation—While we agree with the Administration that there is merit in state administration of the home and community-based program, to minimize the tremendous variation and fragmentation among states that currently exist, especially under Medicaid, the Association believes that state flexibility must be balanced by clear federal standards and federal oversight. Federal standards should require the provision of basic services, promote efficiency, and assure that consumers are protected. Federal oversight should include review of state plans and monitoring of compliance with federal standards. Careful reporting of substandard performance or troublesome trends should be accompanied by strong enforcement tools. Particular attention should be paid to monitoring states so that they do not simply shift just eligible current Medicaid recipients into the program in an attempt to realize windfall savings, without extending services to other vulnerable persons.

State Incentives for Residential Care Alternatives—One way to promote savings through competitive market forces would be to provide strong incentives to assist the development of residential alternatives to nursing home care, such as assisted living. Experience in Oregon, for example, has shown assisted living to be a cost effective, preferred alternative to nursing home care for many frail elderly. Although we are pleased that the home and community-based care benefit proposed would be portable and available to eligible persons in these settings, more needs to be done on the capital and housing side of the equation. Ways to make such residential options affordable to persons with low and moderate incomes should be specifically addressed.

Nursing Home Care and Medicaid Improvements

In addition to a new program for home and community-based care, the President's proposal also would include modest improvements for those who need nursing home care. Specifically, it would: (1) require all states to have medically needy programs under Medicaid; (2) give states the option to increase the level of protected assets for single persons from \$2,000 to \$12,000 for purposes of Medicaid eligibility; (3) increase the minimum Medicaid personal needs allowance from \$30 to \$70 (scaled back from \$100 in the September draft); and (4) create new uniform federal minimum standards for private long-term care insurance policies, together with certain tax clarifications.

Although AARP is generally supportive of these modest attempts to improve Medicaid, millions of Americans would remain vulnerable to impoverishment due to lack of protection against enormous nursing home costs. The single greatest fear which families confront in long-term care is the devastating costs of a nursing home stay, which now averages \$30,000 a year and can exceed \$60,000 in some parts of the country. Studies conducted for AARP in 1989 and 1991 by DYU, Inc. found that while people prefer home care, it is the cost of nursing home care which individuals fear most when they consider their long-term care needs, and it is this concern that appears most related to their willingness to pay increased taxes to finance new benefits.

Long-term care insurance standards—AARP strongly supports the requirement for uniform federal standards for private long-term care insurance. Such reform is long overdue. Findings from studies conducted by the U.S. General Accounting Office, the Office of the Inspector General, and by Project Hope for AARP clearly demonstrate that the current state regulatory system has failed to provide sufficient consumer protection throughout the nation. We do, however, have some questions about the costs and distributional effects of the tax clarifications proposed in this area, particularly for those selling insurance policies.

AARP agrees with many of the proposed standards in the President's proposal. We are particularly pleased by the Administration's approach on two key issues: inflation and nonforfeiture protection. In our view, inflation protection should be offered to all prospective buyers and nonforfeiture protection should be mandatory for

all long-term care insurance policies. These views are consistent with the current standards proposed by the National Association of Insurance Commissioners (NAIC), as well as with the legislation marked-up by this Committee last year.

Inflation protection is extremely important, particularly for younger purchasers, since the value of a policy declines significantly over time without it. The need for inflation protection, however, is relatively easily understood if good information is available. Such protection can be quite expensive and may not be needed by older purchasers, who may be able to get good value by buying a policy with a relatively high indemnity benefit amount. The Association, therefore, believes that standards should require an offer of inflation, accompanied by strong disclosure language, consistent with the President's proposal, which would help purchasers make informed decisions.

Nonforfeiture protection would ensure that, if policyholders pay premiums for a minimum number of years (e.g., five) and are forced for some reason to drop their policy, insurance companies would not be permitted simply to keep all of the premiums collected. Rather, consumers would receive some reduced protection based on how much they have spent in premiums over the years. Many consumers do not realize that the risk of lapsing, or dropping, a policy before ever receiving any benefits is great. According to a recent General Accounting Office report, companies estimate that, on average, about 65 percent of policies will lapse within ten years. An offer of nonforfeiture protection, rather than a mandate, would be insufficient because the risk of lapsing is difficult to predict and accurately disclose, and insurance agents have had a poor record in making such complex disclosures. If structured properly, in the form of a shortened benefit period as opposed to merely providing cash, mandatory nonforfeiture protection can be equitable and affordable.

The risk of lapsing is linked directly to whether companies increase premiums. Stable rates would reduce lapses and provide important consumer protection. AARP is working closely with the NAIC on a premium stabilization proposal that includes: (1) guaranteed level premiums (not permitted to increase for any reason) prior to nonforfeiture protection taking effect (e.g., five years); (2) premium increases limited to 30 percent over a three year period; (3) for policyholders over age 65 or those who have held a policy for at least fifteen years, premium increases limited to 15 percent over a three year period; and (4) for policyholders over age 80, phased-down over time to age 75, guaranteed level premiums.

AARP has also devoted a great deal of time and effort over the years to working with the Congress, the NAIC and others to improve consumer protection standards for long-term care insurance. We look forward to working closely with members of this Committee on this important, complex issue.

Incremental Nursing Home Reforms—If sufficient funding for a comprehensive nursing home program is not available at this time, less expensive incremental reforms could help many people. For example, one option would be to reduce the inappropriately high \$84.50 Medicare Skilled Nursing Facility daily coinsurance and make it more consistent with the extended care benefit available in the President's proposed basic benefit package through the alliances. We also strongly urge that the proposed optional increase in the level of assets protected under Medicaid for single persons (from \$2,000 to \$12,000) be made mandatory, as was originally proposed in the September draft, since states are very unlikely to provide such protection voluntarily. In our view, the amount should be increased beyond \$12,000 so that people need not spend-down to such a low level before receiving protection.

The President's proposal should also do more to promote the key principles of savings and choice for Americans who need nursing home care. The proposal does not address the need to contain nursing home costs, nor does it remedy the access problems that low and middle income applicants experience in gaining admission to the nursing home of their choice. Hospitals and other providers will have incentives to shift costs to this sector if it is the only one not subject to some form of spending limits. These goals could be furthered by making charge data available to consumers and prohibiting discrimination in admissions on the basis of wealth and source of payment.

Proposal for a Voluntary Public Nursing Home Insurance—In the absence of a comprehensive nursing home program, it is necessary to look at range of options that provide Americans with some protection against their greatest fear—impoverishment from nursing home costs. In this regard, Senator Kennedy's Life Care Act, which would provide individuals with the opportunity to voluntarily purchase a nursing home insurance policy from the federal government, merits consideration.

Many who are currently excluded from purchasing such protection in the private sector because of a pre-existing condition would, for the first time, be permitted to buy a policy. The asset protection feature could also help some individuals avoid having to spend-down to very low poverty levels in order to receive some coverage.

In addition, premium dollars would no longer be used to pay for agent commissions, company profits, or marketing costs and policyholders would no longer need to worry about their insurance carrier becoming insolvent.

The proposal does raise some concerns, however. Clearly, it would not solve the problem of lack of protection against expensive nursing home costs for the vast majority of Americans. Premiums would still be too expensive for typical middle class consumers and many would continue to deny that they would ever need nursing home care. In addition, we are concerned that private insurance companies would "skim" the healthiest purchasers and the public program would become a bad risk pool, thereby driving up premiums further to sustain the self-funded nature of the program. In that event, the product would become even more unaffordable.

We recommend that, in order to make the policies more affordable for average Americans, sliding scale premium subsidies be seriously considered. Absent such subsidies, we fear that many consumers would not be able to take advantage of the protection offered. Additional recommendations include strengthening standards for premium stabilization, which would, in the short term, increase premiums, but over the long term would make premiums more affordable for consumers. Coverage should also be expanded to include alternatives to nursing homes, such as in assisted living and other residential care settings.

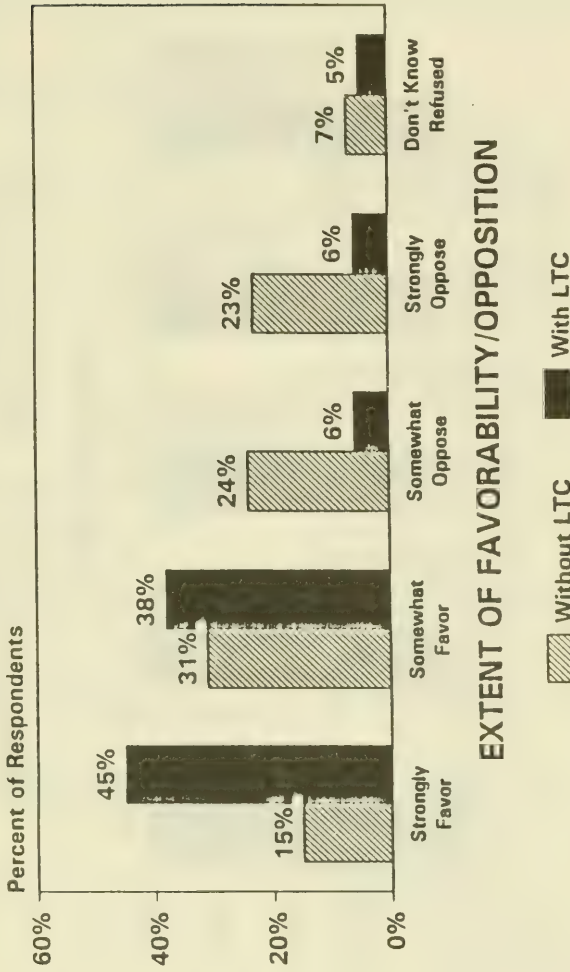
Conclusion

On June 8, 1988, the late Senator Claude Pepper brought a bill covering home and community-based care to a vote on the House floor. Much was said by many members about the need to provide this kind of protection. Even opponents, who argued that the timing was not right, spoke eloquently about the importance of covering services in the home. Just before the proposal was defeated by a 169-243 vote, Congressman Pepper stated:

This is a day for which I have waited and worked, and I might say prayed for, for 50 years—a chance to lighten the burden upon the masses of the people of this country, trying to help those saddled with a long-term illness We can help millions of people to meet crises in their homes that are heart-rending in their character. When are we going to have another opportunity if we lose this one?

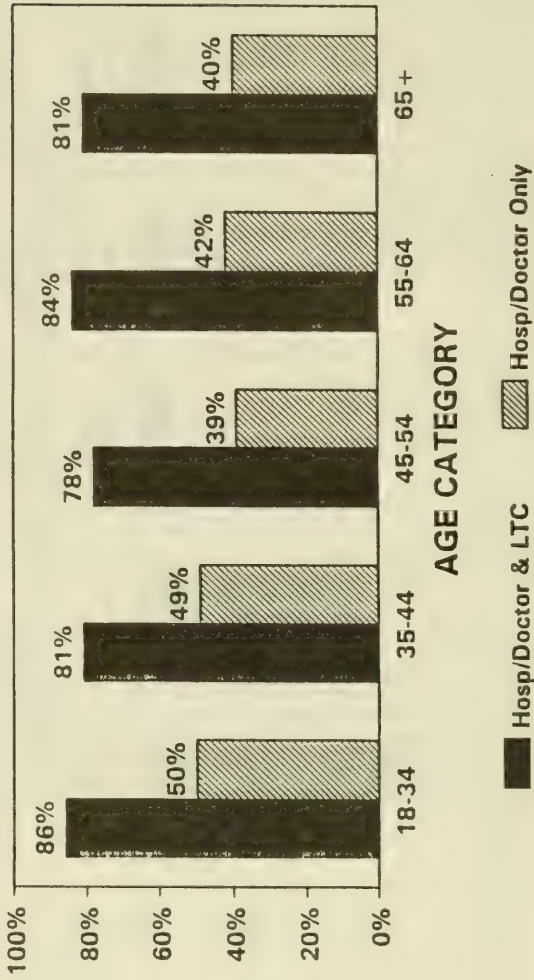
The opportunity has now come. As advocates and policymakers we will, however, need to be very candid with the public and not attempt to oversell the President's proposal on long-term care. The limitations of this program will loom larger in the public's eye in the future if they come to believe that there is more coverage and protection in the program than really exists. The President's proposal does not provide all the answers for everyone in need. But it is a significant start and a vast improvement over our current long-term care "non-system". Our job is to shape and improve the proposal so that it will provide real protection now and a solid foundation for the future.

FAVOR/OPOSE HEALTH CARE REFORM PLAN WITH AND WITHOUT LONG-TERM CARE COVERAGE



AUS/ICR Survey Research Group
Excel Omnibus Study
April 21-27, 1993 (N = 2,020)

**PERCENT FAVORING HEALTH REFORM PLANS
WITH & WITHOUT LONG TERM CARE COVERAGE
(BY AGE CATEGORY)**

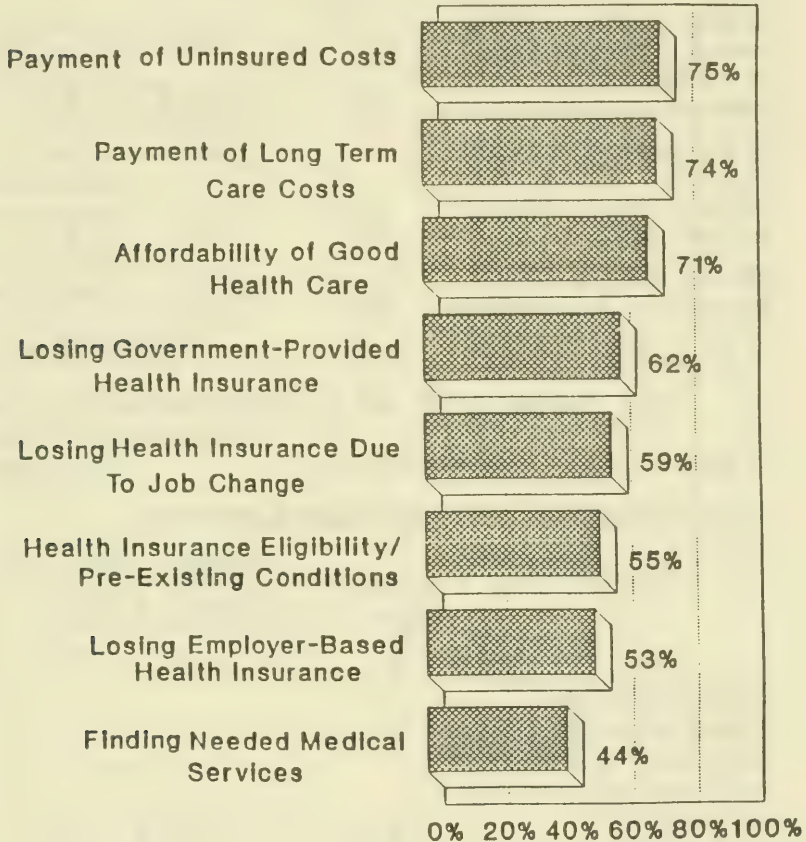


AUS/ICR Survey Research Group
Excel Omnibus Study
April 21-27, 1993 (N = 2,020)

Ratings of Health Care Concerns

Total Sample

Very Concerned About:



ATTACHMENT 4

Ratings of Health Care Concerns

	<u>Total</u> %	<u>Total Women</u> %	<u>Total Men</u> %
<u>Very Concerned</u> ^{1/}			
Being able to pay for costs of health care not covered by insurance/government	75	75	75
Being able to pay for the cost of long term care such as nursing home care	74	76	73
Being able to afford good health insurance	71	70	71

Continued...

1/ Rating of "4" on a 4-point scale

ATTACHMENT 5

Ratings of Health Care Concerns

	<u>Total Women</u> %	<u>Women: Age</u>		
		<u>18-49</u> %	<u>50-64</u> %	<u>65+</u> %
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/government	75	74	82	70
Being able to pay for the cost of long term care such as nursing home care	76	72	85	78
Being able to afford good health insurance	70	69	85	60

Continued...

1/ Rating of "4" on a 4-point scale

ATTACHMENT 6

Ratings of Health Care Concerns

	<u>Total Men</u>	<u>Men: Age</u>		
		<u>18-49</u>	<u>50-64</u>	<u>65+</u>
	%	%	%	%
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/ government	75	75	76	76
Being able to pay for the cost of long term care such as nursing home care	73	69	80	79
Being able to afford good health insurance	71	73	75	58

Continued...

^{1/} Rating of "4" on a 4-point scale

ATTACHMENT 7

Ratings of Health Care Concerns

	<u>Total</u>	<u>Income</u> <u>(\$Thousands)</u>		
		<u>Under</u> <u>25</u>	<u>25-</u> <u>49.9</u>	<u>50+</u>
	%	%	%	%
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/ government	75	80	78	59
Being able to pay for the cost of long term care such as nursing home care	74	77	74	68

Continued...

1/ Rating of "4" on a 4-point scale

Senator WOFFORD. Tony Young, let's go to you.

Mr. YOUNG. Thank you, Mr. Chairman.

I am Tony Young, director of residential and community support services with the National Association of Rehabilitation Facilities. I am appearing before you today as a consumer of long-term services and as a representative of the Consortium for Citizens with Disabilities, a coalition of over 100 organizations representing consumers and providers of services to people with disabilities.

I have several points to make this morning, but the one overriding message that I want to convey to you is this. It is absolutely critical that long-term services be included in the reform of our national health care system. Ignoring long-term services will limit the effectiveness of any reform.

I can tell you from personal experience that effective long-term services can have a profound effect on a person's life. As an individual who is a C-4 quadriplegic, I require assistance with many activities in my life including bathing, dressing, eating, toileting, transferring, and other tasks.

Before I was able to arrange for personal assistance, I spent my time watching television and sleeping. There were many days when I never got out of bed because my family did not have the energy to help me in both the mornings and the evenings, after working all day.

With personal assistance, I have been able to complete a degree in business administration and to work in a series of jobs which have developed into a satisfying career. I have an active social life and participate in a variety of community activities.

There are many strengths to the President's proposal. First, the eligibility criteria do not exclude people by categories such as age, disability, or income. This is a major improvement in eligibility determination approaches.

The proposal also calls for a broad range of long-term services. As you have heard here this morning, individuals and families have diverse needs for long-term services. Comprehensive, flexible long-term services are essential in order to meet these diverse needs, to preserve families, and to support people in their own homes and communities.

The President's proposal does not require individuals and families to impoverish themselves in order to receive long-term services. The introduction of a disability into a family means substantial changes. One of those changes should not be the forced divestiture of all resources. None of these families wants any more than to be able to help their family members stay at home without an undue burden on the family.

Additionally, we should encourage individuals with disabilities to continue to be productive members of society. The proposal maximizes the empowerment of people with disabilities by infusing consumer control into all levels of the long-term services system. Individuals with disabilities and their representatives will constitute a majority of both the Federal and State advisory committees that will design and monitor the new system. Consumers will also be able to choose their own services and service providers, as well as to direct them.

There are substantial investments in productivity in the President's proposal. The tax credits for working individuals with disabilities will be the difference for many people that will enable them to work. Now they cannot afford to work due to the cost of the personal assistance required for them to hold jobs. This is an intolerable waste of talent and skills of entrepreneurs like Bill Smith.

However, there are a number of refinements to the Clinton proposal that CCD would like to suggest. As currently drafted, the severity requirements for eligibility would not cover many people who need long-term services, especially those persons with cognitive and mental impairments. In addition, the criteria for children's eligibility must be refined.

Another improvement involves the range of services that State programs will be required to offer. States must assure that all needs of eligible individuals with disabilities can be met within a State plan. The current copayment schedule outlined in the draft bill raises several problems. CCD recognizes that individuals with disabilities should participate in the financial responsibility for long-term services, but there must be a cap for low and middle-income families on long-term services out-of-pocket costs similar to those placed on out-of-pocket costs for acute care.

All of the individuals who have testified before you today have one thing in common. The promises of the Americans With Disabilities Act for inclusion in the mainstream of American society are meaningless to us without effective long-term services. None of us would ever be able to contribute to the Nation's economic, cultural, or spiritual growth without long-term services.

You can ensure that the promises of the ADA are kept for people with significant disabilities. You can help Bill Smith run his own business again, help Clarence Reed and Otto Menkes live out the rest of their lives in comfort and dignity with their loved ones, and help Rob Miles grow into a participating, contributing adult member of society. You can do these things by making long-term services an indispensable part of health care reform.

Thank you for this opportunity to testify. I would be happy to answer any questions you might have.

Senator WOFFORD. Thank you.

[The prepared statement of Mr. Young follows:]

PREPARED STATEMENT OF TONY YOUNG

Introduction

Good Morning, Mr. Chairman. I am Tony Young, Director of Residential and Community Support Services at the National Association of Rehabilitation Facilities. I appreciate this opportunity to appear before you today as a consumer of long term services and on behalf of the Consortium for Citizens with Disabilities (CCD).

CCD is a working coalition of over 100 national consumer, advocacy, provider, and professional organizations which advocate on behalf of people of all ages with physical, mental, and sensory disabilities and their families. Since 1973, CCD has advocated for federal legislation, regulations, and funding to benefit people with disabilities. My testimony today is presented on behalf of the undersigned members of the CCD Task Forces on Long Term Services/Medicaid and Personal Assistance Services.

As an individual with quadriplegia at the C-4 level I require assistance with many activities in my life, including assistance with bathing, dressing, eating, transferring, travel, shopping, laundry, housekeeping, and taking medications. These services form the foundation onto which I build my life of work and leisure.

These are critical services for me and for many other people with severe physical disabilities. However, in designing a national long term services program, Congress must keep in mind that the causes and consequences of chronic disabilities are highly varied and require significantly different responses on the part of the service delivery system, depending on the nature and extent of the individual's disabling condition as well as the surrounding circumstances of his or her life. An infant with complex medical needs in combination with severe cognitive disabilities will require a much different constellation of services and supports than someone with needs similar to mine. Likewise, a young adult with severe and persistent mental illness needs access to an array of continuing and intermittent supports that would be inappropriate in the case of an elderly individual who no longer is able to perform basic functions of daily living. Formulating an effective national long term service policy, therefore, must begin with an appreciation of the diversity of needs represented among the millions of Americans with severe disabilities and proceed to the creation of financing mechanisms and service delivery strategies that fully accommodate these differences.

Personal situation and systems issues

All of my personal needs are not met by the current service system. While there are some services and supports available, the major funding source—Medicaid—is not available to me unless I impoverish myself. Many states severely limit the duration and scope of personal care that their Medicaid programs will purchase. Furthermore, even if a state has a Medicaid home and community-based waiver program, it may be targeted to elderly individuals or to people with specific types of disabilities and not available to individuals with other disabling conditions. After I became disabled, I became eligible for Medicare after two years but Medicare does not cover any ongoing personal assistance or rehabilitation. These gaps must be filled.

It is fair to say that personal assistance services have not simply influenced my lifestyle; they have enabled me to have a lifestyle. Without the education, employment, mobility, and freedom of choice that personal assistance services have brought to my life, I would have a bleak existence and an even bleaker future. Consider the differences with and without personal assistance services.

Without personal assistance services I spent the majority of my time watching television and sleeping. I watched television because it was my only companion, as I was unable to get out to see friends and meet new people. I slept to escape the boredom of watching television. There were many, many days when I never got out of bed because my family did not have the time or the energy to help me in both the mornings and the evenings, especially after working all day.

The days when I did get up were short days, partly because I had to do so between family members' work schedules, and partly because I didn't get up enough to build up my endurance. Even though I never worried about getting food, drink and medications, there wasn't much more to my life than eating, sleeping, and watching television.

With personal assistance services I have been able to complete a degree in business administration and to work in a series of jobs which have developed into a satisfying career. I manage to pursue an active social and advocacy life, and I have a reasonable expectation that these activities will continue. I find myself thinking of the future in terms of the next few years instead of the next few days. I find myself now living in a world of potential rather than a world of despondency. There is the potential of a home of my own, and a family of my own.

This is not to say there are not problems with my personal assistance arrangements. The current system of long term services does virtually nothing for me. I am not eligible for any subsidies because of my income level. The current tax structure is limited to medical deductions, which are subject to a 7.5% Adjusted Gross Income exclusion, and deductions for personal assistance at the worksite.

Therefore, my family and friends must still spend too much time helping me, because I can only afford about one quarter of the long term services time I really need. I now pay about \$600 a month for 60 hours of services, an average of about two hours per day. The rest of the support time I need, about six hours per day, is provided through a combination of family, friends, and my far-sighted, enlightened, supportive employer. There is no way I could personally afford the full cost of my long term services, which can be as high as \$2,000 a month. In addition, my private insurance covers rehabilitation services and therapies if I need them. My insurance also covers my equipment, such as my wheelchair, my braces, and training to use this equipment properly.

With this system I often receive inadequate personal assistance services in the form of too few hours of services, leading to health problems such as pressure sores

from lack of pressure releases, or urinary tract infections from a lack of fluids (I can't use the bathroom because I don't have the assistance I need, therefore I simply don't drink any fluids). Sometimes I am forced to employ providers with inadequate personal assistance services skills in order to have someone to cover enough hours of basic services such as food preparation and assistance with eating. In addition, I cannot offer my personal assistance services employees typical benefits, including sick and annual leave, or health insurance, rendering it very difficult to recruit and retain quality personal assistance services providers.

I choose to hire my own attendants for certain reasons. People can receive attendant services through home health care agencies and often are required to do so if the services are being paid for by Medicaid. However, if you are paying for services out of your own pocket, agency-run programs are often costly and do not permit full consumer direction.

Simply locating good personal assistance services workers is a daunting task, as is keeping them once they are located. It is difficult for individuals working alone to locate reliable, competent employees to fill personal assistance services positions. I do not have the authority or the resources to investigate the backgrounds of potential personal assistant services providers who answer requests for applications. Too often the only way for me to judge the true character of a personal assistance services provider is to allow the provider into my home and monitor the individual's performance. This is an inappropriate, dangerous procedure.

I have attempted to work with various agencies, including an Area Agency on Aging and a Center for Independent Living, in order to recruit workers. Efforts to create registries of potential workers have had limited success, at best. These agencies, despite their best efforts, do not now have the resources to maintain a system that could offer pools of eligible workers, emergency workers, or orientation programs for these workers. A better, more comprehensive system must be established.

I manage despite these problems, although at times I feel as though I am operating a personnel department in order to conduct my professional and personal life. Maintaining an adequate personal long term services system consumes a great deal of my time and energy, in addition to money. I am fortunate that I have a job which pays me enough to afford what I can, and that I have an employer, family, and friends that help to make up the staggering difference. Few others are as fortunate as I am. Given the age of some of my family members, my good fortune will end in a short time as well.

This is my personal experience with long term services. Other individuals with different disabilities will have different service needs, hour requirements, and circumstances to contend with. A person with a cognitive disability might need several hours per week of assistance in managing their money and making financial decisions. In another instance, a person might need a reader, sign language interpreter, or oral interpreter to communicate with landlords, relatives, or shopkeepers.

People with other long term support needs, such as individuals with mental retardation or developmental disabilities or people with serious mental illness, typically receive their services through a variety of specialized provider agencies. Many of these community providers serve individuals who are receiving Medicaid-reimbursable services. However, access to these services depends on the state you live in and your level of income and resources. Again, Medicaid services are limited to individuals with very low incomes who are among the most vulnerable. But I would prefer not to make myself more vulnerable by becoming poor just to receive services. As I said, I want to be productive and live my life.

Many people with disabilities are in jeopardy of being placed in a long term care institution, such as a nursing home, psychiatric treatment facility, or a residential center for people with developmental disabilities. The existing federal policy bias toward using institutional care when a person has a particular diagnosis or may need a high level of service must be reversed. I know I would never voluntarily choose this option, as most others would not.

Varying long term service needs: some examples

The following are brief descriptions of various people with disabilities of all ages and the circumstances of their lives. Long term services reform as a part of the health reform package will be vitally important to them all.

A ten year old boy in Connecticut who required 24-hour a day ventilator support lived in a hospital for the first three years of his life. With intensive respiratory interventions and exercise, he has been able to reach the point where he lives at home with his family, attends public school in the fifth grade, and requires ventilator support only at night while sleeping. Continued access to such support will be vital to him.

A twenty-eight year old man lives in a nursing home in Virginia because he is unable to receive the combination of nursing services, personal assistance services, and companion services which he needs to remain in his home. As a result of multiple gunshot wounds, he is paralyzed from the neck down, requires a ventilator, and uses a motorized wheelchair controlled by a mouthstick. His marriage has ended and he is now able to see his two children, ages seven and four, in short visits spread over the year, totalling only about 48 hours a year. With proper personal assistance and other long term supports, he could live in his home community and participate more fully in the lives of his children.

A young woman, age 24, with cerebral palsy and mental retardation has benefited significantly from the Medicaid community supported living arrangements services program. She lives in her own apartment with a roommate and counselor, has found a job, and pays taxes. She has formed new friendships and has increased her independence, access to the community, and her self esteem. Although she has made great progress, she will continue to need long term services and supports for the foreseeable future.

A twenty-five year old man in Maryland who is diagnosed as having paranoid schizophrenia has spent many months in psychiatric hospitals over the last several years. Although his disability and numerous hospitalizations had a serious impact on his ability to participate in school, he eventually earned his diploma. Through a community outpatient psychiatric rehabilitation program, he receives numerous long term support services which are enabling him to become more independent in the community. He receives assistance in keeping his medications under control, learning to use public transportation, learning job seeking skills and appropriate business attire and behavior, managing money and paying bills, and is learning to live on his own. He will need continued support in various aspects of his life in order to maintain and increase his ability to live independently and to avoid future hospitalization.

A seventeen year old girl is experiencing major changes in her life as a result of traumatic brain injury during a car accident. She is having a slow recovery, is experiencing learning problems, frustration and extensive social changes, and attends school only half day while she receives rehabilitation services everyday. As she matures and as the extent of her injuries are revealed, she will need various supports over time, including services to assist her in making the transition from school to work and to assist her to become as independent as possible within her community.

In Wisconsin, a young boy born with cerebral palsy and sensory impairments requires a tracheostomy tube to help him breathe, a gastrointestinal tube to help him eat, and other extensive medical, health, and social supports. He lives at home with his family, attends his neighborhood school, and relies on a number of basic supports from numerous sources such as the school system, private insurance, Medicaid waiver services, and state and county community and respite care services programs. While managing services from many different sources is complicated, the mix enables him to live at home and to stay out of an institution. He will continue to need support at school, specialized therapies, prescription medications, special diets, personal assistance, adaptations such as a lift on the family van, and support for community living as he grows older.

A retired fifty-six year old woman with multiple sclerosis has periods when she is able to take care of herself with just a few hours of personal assistance a day. However, there are periods when her condition worsens and she is completely paralyzed, sometimes leading to hospitalization and the need for total care when she returns home. She needs a wide range of long term services that can be provided in varying intensities depending on her needs at a given time. However, her retirement income—a small pension and some income from investments—is insufficient to pay for these services. Medicaid does not provide the home and community based services she needs and, to be eligible for nursing home care when she needs total care, she would have to impoverish herself by spending all of her income-generating assets, at which point she would no longer be able to afford to live in her own home.

CCD approach

CCD has considered the development of a comprehensive long term services program to be a critical need area for many years. A comprehensive long term services program would include supported living services, personal assistance services, supported employment, assistive technology devices and services, and an array of community support services for people with disabilities.

CCD's Task Force on Long Term Services/Medicaid has been working on issues related to the long term service provisions of Medicaid, while other CCD Task Forces, such as Housing, Employment and Training, and the Technology Task Forces have been working on other aspects of this comprehensive service system.

A relatively new Task Force on Personal Assistance Services was created in 1990 to address the critical personal assistance component of the system.

The CCD Personal Assistance Services Task Force includes representatives from across the disability community, including people with physical, cognitive and other mental impairments, including mental illness, and sensory impairments. Together we worked to refine the draft bill Personal Assistance for Independent Living originally produced by the World Institute on Disability.

CCD established working groups on crucial issues of system design; training and compensation; quality assurance; eligibility & services; and due process. The deliberation of these groups lead to the development of a concept paper, Recommended Federal Policy Directions on Personal Assistance Services for Americans with Disabilities, that sets forth the philosophies and principles that CCD believes any comprehensive personal assistance services program must meet. This document is included as Appendix 1.

CCD has been meeting on an ongoing basis with the American Association of Retired Persons, the Long Term Care Campaign, the Older Women's League, the Alzheimer's Association, Families USA, and other groups representing elderly people to discuss and compare our long term care proposals with a view toward defining areas of consensus regarding long term services between the disability and aging communities. Ideas, views and opinions are exchanged among the groups through a number of meetings and forums. Together, CCD, AARP, and the Alzheimer's Association have presented consensus recommendations to the Administration Working Group on Long Term Services. While there has not been total agreement in all areas, there is enough common ground among the groups to establish an ongoing dialogue and a continuing working partnership.

Reaction to President Clinton's proposal

President Clinton's proposals on long term services have many strengths. He calls for a bold new commitment of \$65 billion over five years for services that are vitally need by people with significant disabilities. If I am able to leave you with only one message today, it would be this: It is absolutely critical that long term services be included in the efforts to reform our national health care system. We must stress that ignoring long term services will short-change many people and limit the effectiveness of any health care reform.

There are many positive aspects to the President's plan and some areas where the plan can and must be strengthened. CCD is committed to work together with the Congress and the Administration to ensure that the best possible reform program be enacted. Given the timing of the presentation of President Clinton's bill and the scheduling of this hearing, the following comments are based on numerous oral updates by Administration officials, previous drafts of the proposal, and a very preliminary analysis of the new bill. After we have more thoroughly analyzed the bill and received clarifications from the Administration, we will submit additional comments to the Congress.

A. Strengths of the President's proposals

There are many commendable components in the Clinton long term service proposal.

1. **New Commitment to Long Term Services**—First and foremost is the President's willingness to commit new federal resources—an estimated \$65 billion dollars over the next five years—to expanding and improving long term services that are desperately needed by Americans with significant disabilities. This commitment will enable thousands of people with disabilities to access education and training programs, hold jobs, and participate in community activities—often for the first time in their lives.

2. **Emphasis on Home and Community Services**—CCD is pleased with the Clinton Administration's emphasis on expanding access to home and community based services rather than institutional services. In general, home and community based services are more cost effective than institutional services and afford people with disabilities greater opportunities to become contributing members of society. The overwhelming desire of most people with disabilities is to remain in their own homes and communities, while receiving the support services necessary to remain as independent as possible.

3. **Eligibility Criteria**—The President's plan takes a positive step forward in attempting to cover people of all ages with all types of disabilities—cognitive, mental, and physical. Historically, other proposals have excluded people on the basis of one type of disability, such as mental illness; CCD considers that approach unacceptable. The President's proposal also allows eligibility for all income levels, thereby beginning to address the marriage penalties of the income-based programs and the

problem of people having to impoverish themselves in order to have the assistance they need to survive and prosper. It also addresses the work disincentives issue, where people who are receiving needed services accept a job, lose their benefits, and yet do not earn enough money to meet their basic living needs and purchase their disability-related goods and services.

4. **Basic Philosophies**—The disability community is delighted to see that the Clinton proposal contains many principles and philosophies that we believe must be a part of any long term services system if it is to be effective. These principles include a commitment to consumer directed services, an option for the use of vouchers or direct cash payments, consumer involvement in planning the state long term services program, and individualized service needs assessments and plans of services.

These directions are particularly important because of the changing nature of the entire disability services system and we applaud the Administration's recognition of them. Services for individuals with disabilities historically have been delivered in a paternalistic manner. In light of the promise of empowerment implicit in the Americans with Disabilities Act, people with disabilities now expect to exercise an increasing degree of control over their lives, their rehabilitation and their support systems. Involvement in the design, direction, management, and assessment of their individual support services enables people with disabilities to exercise a degree of control over their own lives that is essential to physical and emotional well-being.

The ability of people with disabilities to participate actively at the planning level of long term services means that there will be a greater chance that the service system ultimately will meet the needs of those it is intended to serve. Given the number of jobs that will be created by a new \$65 billion program over five years, this program represents an unique opportunity to employ some of the persons with disabilities in America (67 percent of whom are not working) through their participation in policymaking, administration, management, and direct service jobs that will be created.

5. **Tax Treatment**—The proposed tax credits and changes in medical care deductions will help to offset the extraordinary expenses of living with a disability and assist people with disabilities to enter the workforce by giving them a measure of economic equity with those who do not need to pay these extraordinary costs.

6. **A Good First Step**—CCD believes that the President's long term services plan represents a significant beginning for a system that should ultimately be comprehensive. While it is desirable to make long term services available right away to all individuals with disabilities who need them, CCD recognizes that fiscal restraints will necessitate the gradual phasing in of coverage in some orderly fashion. We are concerned about phasing in this coverage in an equitable manner so that people with varying types of disabilities and economic circumstances will be treated fairly and in a manner to ensure that their needs are appropriately met.

B. Issues to be addressed in the Clinton plan

In the previous section, I have described the numerous positive aspects of the President's proposal for long term services reform and, in particular, those areas which reflect the principles and philosophies which the disability community believes must be included in any true reform of long term services. In this section, I want to draw your attention to various issues that CCD has identified which raise serious concerns about the effect of the proposal on people with disabilities. We believe that these are not insurmountable obstacles and we look forward to working with the Committee and the Administration to resolve these and other issues.

1. **Eligibility Criteria**—The eligibility criteria contained in the proposal are too limited in several ways. Taken as a whole, the criteria would not cover many people who clearly need long term services. The President's principle of universal coverage would not apply to long term services where eligibility is so limited. Concerns regarding the specific criteria are as follows.

According to the Administration's own estimates, only about 25 percent of the people who need long term services and supports will be eligible to receive them under the proposed new, universal home and community-based funding authority. The use of the "3 out of 5 activities of daily living (ADLs)" test will leave many people with physical disabilities with substantial service needs without coverage.

The Administration-proposed equivalency criteria applicable to people with cognitive and mental impairments are flawed and would extend eligibility to only a small percent of people who need long term services. As an example, the criteria for mental retardation would cover people with what was formerly known as "severe or profound mental retardation". Those categories include only about 5 percent of individuals with mental retardation and exclude many people whose disabilities are severe enough to qualify them for Supplemental Security Income on the basis of I.Q. alone. Although people with mental retardation might qualify under the other eligi-

bility criteria, we anticipate that tens of thousands of people whose mental retardation, while not "severe" or "profound," nevertheless constitutes a very severe disability, would not qualify for this program since the ADLs are more targeted to the needs of people with physical disabilities.

Earlier drafts used I.Q. to assess eligibility. The use of I.Q. as a sole determiner of functional ability is outmoded and unacceptable. The use of I.Q. as a sole eligibility criteria does not reflect best or current thinking in the field of developmental disabilities. (We are pleased that the new legislation appears to have removed that test.) Indeed, the community representing people with mental retardation has moved beyond the mere classification of people by test score, which historically has perpetuated negative and stereotypic attitudes about persons with significant disabilities, to viewing the circumstances and competencies of the person holistically. A new definition of mental retardation, recently adopted by the American Association on Mental Retardation (AAMR), reflects this more positive, updated approach to assessment. AAMR's definition is attached as Appendix 2.

In addition, the criteria for people with severe cognitive or mental impairments should not be predicated on criteria that is used for commitment to an institutional setting—i.e., "the applicant poses significant danger to self or others." An earlier draft included such language. A severe mental illness is characterized by episodic or persistent symptomatology. Successful community support programs have evolved to prevent or compensate for symptoms associated with acute episodes and to decrease utilization of institutional care by providing seamless access to services that include rehabilitation and assistance in other areas such as: nutritional needs, including purchasing, storing, and preparing food; taking medications; and budgeting for food, clothing, and shelter. Similar services are often critical to people with cognitive impairments as well. The standard mental status exam which is being proposed by the Clinton Administration has yet to be developed and validated. We want to ensure that people with serious cognitive or mental impairments who require extensive ongoing services and supports are not excluded by the use of inappropriate criteria. The draft bill presented to Congress includes some changes in reference to the need for supervision and in the use of instrumental activities of daily living. We are further analyzing the impact of these changes.

Finally, the criteria for use with children is far too limited. It would cover only children under age six who would otherwise require hospital or institutional care. This standard would, once again, use institutional need as the yardstick for eligibility, thereby furthering the institutional bias which already permeates the Medicaid program. The need for and availability of home and community services should not be benchmarked against institutional admissions criteria in the case of either children or adults. An earlier draft required that the child also be technology dependent. Such a requirement would be severely limiting and would likely leave children with equivalent disabilities who do not depend on respirators or other technological devices without the home based support that they need. Finally, it is not clear what happens to children over age six who otherwise meet the children's criteria and to children of any age who might qualify under one of the other criteria. Are criteria that are standardized on the adult population to be used in establishing the eligibility of children over six years of age?

CCD had submitted to the Administration proposed criteria which would attempt to reach people who do not meet the ADL and other tests yet have disabilities at levels equivalent to the 3 ADL criteria. Such criteria would give the Secretary flexibility in assessing other circumstances and factors for eligibility as needed. In addition, CCD's proposed criteria would have used the 551 functional approach (for evaluating disability only) for all children from birth to 18 years of age, that is: inability to function independently, appropriately, and/or effectively in an age-appropriate manner. We urge reconsideration of this feature of the Clinton proposal and attach suggested substitute criteria as Appendix 3.

CCD believes it is important to note that, although the eligibility criteria are flawed, the proposal reflects an understanding of the need to use different approaches for determining eligibility for people with differing disabilities. This is within the expressed intent of covering people with all types of disabilities, regardless of diagnosis.

2. Scope of the Basic Service Package—There are two issues which must be addressed regarding services to be covered under the new home and community long term services program. One is the breadth of the service package and the other is the definition of personal assistance services itself.

a. Breadth of the Basic Service Package—Regardless of the ultimate definition of personal assistance (discussed below), the proposed program must recognize that personal assistance services is only one element of the array of long term services and supports required by people with severe disabilities. As I stressed earlier in my

testimony, severe disabling conditions occur in many forms and, thus, a broad array of services and supports must be available to appropriately address the needs of all eligible participants. There is a real danger that many eligible individuals—especially people with significant mental and cognitive disabilities or multiple disabilities—will be denied the full range and intensity of community services they need if this new federal funding authority is narrowly construed by the states. Given the fact that federal funding levels would be capped and the states granted broad discretion in determining the range of services to be provided (i.e., other than personal assistance services), we believe that this danger is a real possibility which should be seriously addressed.

CCD believes that the services which are considered to be state options under the President's proposal should, in fact, be part of the basic service coverage in each state, in addition to personal assistance services. As stated in the proposal, these services include "any other community based long term care services including: case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, habilitation and rehabilitation, supported employment and home health services not otherwise covered under Medicare, private insurance or through the basic health plan."

In addition, states should be required to demonstrate in their state plans that the range of services that it will offer will be sufficient to meet the needs of all eligible people regardless of the type of disability they have, their age or the level of complexity posed by their disabling condition. In preventing the furtherance of the use of institutions, it is important that people have access to a full range of needed services and that they not be forced to accept institutional services for lack of adequate and appropriate home and community services. Costs should not be an issue in making these changes since the level of federal financial participation is capped. CCD's recommendations would, however, assure that people with disabilities will be eligible for similar services no matter where they live thus ensuring interstate "portability" of long term services and supports and that they will not be subject to the vagaries of state-level political decision making regarding vital services which they require through this joint federal/state program.

b. Definition of Personal Assistance Services—The the Clinton plan, personal assistance services for the new home and community services program are defined by the state and must include at least "hands-on and stand-by assistance, supervision, and cuing with activities of daily living." CCD believes that the inclusion of supervision, standby assistance, and cuing is important and should remain in the definition.

However, CCD is concerned that the definition only references activities of daily living. This aspect of the definition will make the services useful primarily to people with physical impairments who meet the ADL test and will not address the personal assistance needs of people with mental or cognitive impairments who are otherwise eligible. CCD recommends a broad definition of personal assistance services which would include the services needed by people with cognitive and other mental impairments and sensory impairments. This definition can be found in the paper Recommended Federal Policy Directions on Personal Assistance Services for Americans with Disabilities in Appendix 1.

Again, broadening the definition to include essentially any services which will assist the functioning of an individual should not affect the cost of the proposal since the home and community based services program is capped. Broadening the federal minimum definition will, however, allow the states to be more flexible in meeting the needs of all eligible people in the program. We note that the Administration's September 7 description of its long term care proposal included a much broader definition of personal assistance services in the section dealing with the tax credit.

The proposal makes a distinction between agency-administered and consumer-directed services. We note that, while consumer-directed or voucher programs may be the purest form of consumer control, even agency-run services can be designed to be consumer-directed in many respects.

3. Medicaid Long Term Services for People with Low Incomes—Central to our analysis is the understanding that the September 7 Administration-proposed low income home and community services program has been eliminated and that, instead, the Medicaid program will continue to provide both home and community and institutional long term services to people who are eligible for Medicaid. Given the fact that the new eligibility criteria for the Administration's new long term services program is much more limited than the current eligibility criteria for Medicaid long term services, the continuation of community services through Medicaid is absolutely essential to meet the needs of people who are now eligible for Medicaid as well as people who may become eligible for Medicaid in the future. For example, under the Medicaid optional programs now available to people with serious mental

illnesses (targeted case management, clinic services, and rehabilitation services), innovative long term services have reduced unnecessary or prolonged institutional care, homelessness (which can be prevented or ameliorated with assertive community treatments when not restricted by arbitrary limitations) and inappropriate incarceration of children and adults when there are no other places of treatment or supports because of inadequate funding in the health care system.

CCD believes that it is necessary to continue to make improvements to the Medicaid long term services programs so that they will better reflect state of the art approaches in serving people with disabilities. Such improvements are needed in: the home and community based waiver program (including the expansion of the definition of habilitation services to include supported employment for all waiver recipients), making the community supported living arrangements services program a coverage option under all state Medicaid plans, eliminating the discriminatory treatment of low income people with mental illness under the Section 1929 home and community-based state plan coverage option, the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) option, and improving administration and regulation of OBRA 1990 PASARR requirements regarding inappropriate nursing facility admissions. CCD has previously submitted to Congress specific proposals for dealing with each of these limitations in current Medicaid policy; and, I would stress, none of them have been shown to cause a significant increase in federal-state Medicaid spending.

It should also be noted that most current Medicaid long term services are optional to the states. In conjunction with the differential federal match available to states for services under the new home and community program (expected to be significantly higher than the match for the remaining Medicaid program), there is significant fear that states will divert existing Medicaid matching dollars that currently are being used to furnish community services to low income people who need them but who would be ineligible under the new program's stricter eligibility criteria. This potential situation raises serious issues of long term security for individuals and their families and must be addressed in any forthcoming legislation.

4. Consumer Involvement—As discussed above, the Administration proposal rightly includes a new focus on consumer involvement in various aspects of federal and state policymaking. CCD believes that this positive direction should be enhanced with greater attention to consumer involvement in state planning and program design, and in quality assessment of the services and supports and the system through which they are provided. CCD submitted extensive consumer participation recommendations to the Administration earlier this year. These recommendations, which would enhance the role of consumers and their representatives at the policy and implementation levels, are attached as Appendix 4.

In addition, it is crucial that the proposed Medicaid Commission, which we understand is to be appointed to determine the future of Medicaid acute and long term services, have adequate representation and input from all areas of the disability community. As major consumers of Medicaid acute and long term services, the disability community must be heard and must be a full participant in efforts to develop the Commission's recommendations.

5. Institutional Bias—The current Medicaid program contains clearly recognized institutional biases which CCD believes should be eliminated and thus should not be carried forward into or exacerbated by any new home and community services funding authorities. In fact, it is our hope that the creation of a new community long term services program would help to reverse these current biases. However, there are some features of the proposal which we believe threaten to establish new biases in favor of institutions. They include: establishing a cap on expenditures for the new community services program while the nursing facilities and ICFs/MR remain uncapped; new mandates for medically needy spend-down programs for institutional services but not for community based services; and proposed increases in the resource limits and personal needs allowance, which are sorely needed but which are targeted only to people living in institutions without comparable income and resource protections for people living in the community. [The (previously mentioned) low income proposal contained features which many believe would have further exacerbated the institutional biases of the Medicaid program. We believe that these features were completely unacceptable, but will not dwell on them here.] We urge Congress to be vigilant about truly promoting community services.

6. Equity in Co-Payments—As in the acute portion of the plan, CCD believes that more work is needed on the co-payment sliding scale. The amount an individual or family (with a member living at home) is required to pay should also be capped, based on a percentage of income. Otherwise, the current co-payment structure may make home and community long term services exorbitantly expensive for people with low incomes. Particularly since people with higher incomes will be eligible for

services, it is imperative that the costs of services not be out of reach of low and middle income individuals and families. This would be especially true of individuals with high service needs and costs. Is it fair that a family of four with a net taxable income of \$24,000/year which is supporting a ventilator-dependent child at home, whose costs total \$85,000, should pay fully 10 percent of the cost with no cap, while they would incur no costs if the child were institutionalized in a Medicaid certified long term care facility? Similarly, should not a couple with net income of \$125,000/year and community services costs of \$8,000 be required to pay more than \$3,200 per year?

Further, it is unclear what impact the tax credit will have on low and high income people in relation to their co-payment costs. We are concerned that the tax credit does not appear to be available for working families with children with disabilities and families with non-working adult members with disabilities. In addition, there is great concern within the disability community with the proposed prohibition against allowing states to use income as a basis for allocating resources during the phase-in, since this will prevent states from targeting resources to those most in need.

7. Children—Special attention must be paid to the effects of the proposal on children. Children who lose Medicaid coverage because they are covered by the alliance health plans should not lose their access to important therapy and other long term services and the protections of the Medicaid Early and Periodic, Screening, Diagnosis, and Treatment program (EPSDT). Forcing these children to go without cost-effective extended services would be unacceptable. The failure to fully cover these vital services also would jeopardize early intervention and education-related services under Part H and Part B of the Individuals with Disabilities Education Act by withdrawing a major funding source at a key time during implementation. This would be especially important for infants, toddlers and children who do not meet the eligibility test for the new program. We are still analyzing the draft bill's approach to coverage of these essential services.

8. Payment Rates—Payment rates for providers must be high enough to enable them to cover legally required employee benefit payments such as Social Security, Medicare, tax withholding, and the new employer-mandated health insurance premiums. This is particularly an issue in voucher and cash payment situations where the individual with a disability directly hires his/her personal assistants. Experience in several states has shown that people either have to go without essential services or they get the services by paying below legally required minimum wages and benefits. We are reviewing other issues related to providers in the draft bill.

9. Other Issues—There are numerous other critical issues which will need to be addressed in ensuring that the proposal can meet the needs of people with disabilities. These include: the need to address psychiatric services required over time which are beyond those covered by the basic benefits package; the need to resolve issues regarding state medical practice and nurse practice acts in relation to health-related tasks performed by personal assistance providers such as medication administration and catheterization; the relationship between acute health services and long term services for people with disabilities including clarification of treatment of services such as "outpatient" rehabilitation services which might be considered acute or long term services; an assessment of the impact of the state option for making capitated payments to health plans or other providers for community based long term services; and the length of time until full implementation of the long term services proposal. The relationship between acute health and long term services is problematic for all people with serious and persistent physical, cognitive, and mental disabilities; for people with psychiatric disabilities, there is the additional question of the linkage to essential long term services for people who exceed limitations for non-residential intensive services until the year 2001 when full coverage is scheduled to be in effect.

Again, CCD looks forward to working with this and other Committees of Congress to address the President's long term services proposal. We believe that long term services are a critical component of health reform and that the President has made a significant and important commitment and step forward with the proposal of a new home and community long term services program to serve people with disabilities of all ages without requiring impoverishment for eligibility. We urge Congressional support of this commitment and for including a strong long term services component in legislation to restructure the American health care system. We pledge to work with you to ensure the availability, appropriateness and effectiveness of such supports for all people with disabilities.

APPENDIX 1

POSITION PAPER—THE CONSORTIUM FOR CITIZENS WITH DISABILITIES

Introduction

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over 70 national disability groups. At its 1991 Annual Meeting in January, CCD established a Task Force on Personal Assistance Services (PAS). The Task Force's charge has been to develop recommendations for crafting comprehensive federal legislation to promote expanded and more equitable access to a full array of lifelong personal assistance services for Americans with disabilities of all ages.

What is personal assistance?

Personal assistance is defined as one or more persons assisting another person with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance from another person with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

The next challenge

CCD and other disability organizations view the passage of comprehensive federal personal assistance services legislation as essential to realizing the full promise of the Americans with Disabilities Act (ADA). The ADA extends full federal civil rights protections in the private and public sectors in employment, transportation, public accommodations and communication to all of the Nation's 43 million citizens with disabilities. In doing so, in President George Bush's words, it is meant to "bring the shameful wall of exclusion tumbling down." For many, this wall will not fall on its own accord, however. An estimated 9 million Americans with varying disabilities require access to an comprehensive array of personal assistance services in order to truly make the promise of ADA a reality in their every day lives. This paper will present the Task Force on Personal Assistance Services' major findings and recommendations for developing comprehensive federal legislation to ensure greater, more equitable access to personal assistance services for Americans with disabilities throughout our Nation. Specifically, it will outline what the components of such legislation should be in regard to its eligibility, services, individual service planning, training, compensation, quality assurance, rights protection/due process and system design requirements. The Task Force expects to develop and disseminate a second position paper on preferred means for financing personal assistance services.

Who should be eligible?

Any child or adult should be eligible for PAS who: (a) has a permanent or temporary physical, sensory, cognitive or mental impairment; (b) has an impairment which substantially limits one or more major life activities; and (c) requires personal assistance services as defined in the legislation.

The term "major life activities" should be defined to include every day tasks such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, remembering, concentrating, reasoning, information and stimulus processing, understanding, and working.

Income

Individuals who meet the criteria set out above should be eligible for personal assistance services under this legislation regardless of their income. Any child or adult eligible for PAS whose income falls below 300% of poverty should receive such services at no cost. States may wish to charge eligible persons whose incomes exceed 300% of poverty for some portion of the services they receive based on a sliding scale. However, no eligible individual should pay more than 2% of their net income, after disability related expenses are deducted, on personal assistance services funded under this legislation. Additionally, no resource test should be applied to the nonincome assets or marital status of eligible individuals. Children under 18 years of age should be eligible for PAS on the basis of their own incomes and not the incomes of their parents. Cost-sharing requirements should be based on income adjusted for out-of-pocket disability related expenses.

Personal assistance services guiding principles

A wide variety of personal assistance services should be made available to eligible individuals under a federal PAS statute.

Such services should be designed to:

- be guided and directed by the choices, preferences and expressed interests and desires of the individual;
- increase the individual's "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (as called for in the National Council on Disabilities' Policy for Persons with Disabilities, 1983);
- enable PAS users to select, direct and employ their own paid personal assistants, if desired;
- enable PAS users to contract with an agency for these services, if desired;
- foster the increased independence, productivity and integration of the individual into the community;
- be easily accessible and readily available to all eligible persons where and when desired and needed;
- meet individual needs irrespective of labels;
- allow payment to family members for the extraordinary¹ personal assistance they provide;
- be provided in any setting, including in or out of the person's home;
- be based on an individual services plan; and,
- offer PAS users of all ages the opportunity and support needed to assume greater freedom, responsibility, and choice throughout life.

What personal assistance services should be made available?

Personal Assistance Services funded under any comprehensive federal PAS legislation should include:

1. **PERSONAL SERVICES** including, but not limited to, those appropriate for carrying out activities of daily living in or out of the home including, but not limited to, assistance with bathing and personal hygiene, bowel and bladder care (including catheterization), dressing and grooming, lifting and transferring, eating (including feeding), giving medications and injections, menstrual care, operating and maintaining respiratory equipment and the provision of assistive technology devices and services;
2. **HOUSEHOLD SERVICES**, including, but not limited to, assistance with meal planning and preparation, shopping, light housekeeping, laundry, heavy cleaning, yardwork, repairs and maintenance;
3. **CHILD AND INFANT CARE ASSISTANCE** for eligible persons with disabilities who are the parents of children under the age of 18 meant to assist them in carrying out the functions of parenting at times when they would typically do so if they did not have a disability (e.g., assistance with diapering, feeding, lifting or transporting a child);
4. **LIFE SKILLS SUPPORT SERVICES**, including, but not limited to, assistance with money management, planning and decision making including computer assisted directions, home management, use of medications, following instructions, positive behavior management, companion or roommate services which provide regular supervision up to 24 hours for daily living, peer support, advocacy, and support for participation in social, community or other activities. Life Skills Support Services assist the individual to acquire, retain, regain, improve, or execute the self-help, socialization, decisionmaking, and adaptive skills necessary to achieve and maintain independence, productivity and integration and to live successfully in his/her home. These services can include training, prompting, cuing, support or substitute functioning;
5. **COMMUNICATION SERVICES** including, but not limited to, assistance with interpreting, reading, letter writing and the use of communication devices, augmentative communication devices and/or telecommunication devices;
6. **SECURITY-ENHANCING SERVICES**, including, but not limited to, monitoring alarms or systems and making or arranging for periodic contact in person and/or by telephone;
7. **MOBILITY SERVICES IN AND OUT OF HOME**, including, but not limited to, escort and driving, mobility assistance including on the use of public transportation;

¹Extraordinary personal assistance services will be clarified in report language. That language will define these services to be those that are above and beyond the tasks that family members would perform for each other under ordinary circumstances. Criteria will be developed to define above and beyond. Finally, we will try to give an example of what we mean using a kid.

8. **WORK-RELATED SUPPORT SERVICES** including, but not limited to, ongoing services to assist an individual in performing work-related functions necessary to obtain and retain work in an integrated work setting, and to fulfill the functions of a job and personal services on the job;

9. **SERVICE COORDINATION** including assistance with recruiting, screening, referring and managing personal assistants;

10. **ASSISTIVE TECHNOLOGY SERVICES**, including assistance with evaluating the needs of an individual in his or her every day environment; purchasing, leasing or obtaining assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; coordinating and using other therapies, interventions or services with AT devices (e.g., those associated with existing education/rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate the family; and training or technical assistance for personal assistants; and

11. **EMERGENCY SERVICES**, including substitute or back-up services or any of the above services needed on an emergency basis. Back up or substitute services shall be made available when usual PAS providers are unable to provide the service.

12. **EDUCATION SERVICES** children and adults with disabilities needing PAS shall be offered such services as part of their right to inclusive education as well. Such education and PAS shall include age appropriate opportunities to learn to use and control PAS effectively.

Such services would be provided in addition to any other services to which the individual is entitled under the Rehabilitation Act, the Individuals with Disabilities Education Act, Title III of the Older Americans Act, Titles V, XVIII, XIX, and XX of the Social Security Act or other public programs or private insurance.

Individual service plan

An Individual Service Plan (ISP) should be developed in conjunction with each user of personal assistance services funded in whole or part under a federal PAS statute. To the maximum extent possible, each ISP should be based on the individual's self-assessment of their needs or that of their legally appointed representative and/or advocate.

The Single Point of Entry shall be responsible for:

- making an eligibility determination based on the individual's self-assessment or other user friendly assessments; and,
- working with the PAS user and/or their legally appointed representative and/or advocate to prepare a mutually agreed upon written ISP based on these assessments.

At a minimum, the ISP should identify and describe:

- the personal assistance services' needs of the user, including the extraordinary personal assistant needs of a child or minor with a disability;
- the type(s) and frequency of the personal assistance services which will be provided to the user under the PAS Program;
- the type and frequency of the services which will be provided to the user by alternate resources;
- the type(s) and frequency of needed personal assistance services which will not be provided to the user through any means (i.e., unmet needs);
- the timelines for providing PAS to the individual;
- the qualifications and/or skills required by a personal assistant to perform the services;
- to what extent the user is capable of, or willing to, assume responsibility for managing/coordinating their own services and what type of management training, if any, should be provided to assist the PAS user or their legally appointed representative and/or advocate to do so;
- the current PAS arrangements and protect by grandfather clause those relationships declared to be satisfactory by the PAS user with reasonable and periodic adjustments in hours, wages and benefits;
- the outcome-based measures of performance on which the quality of the service(s) will be evaluated, and
- the type and frequency of the quality assurance steps to be taken to ensure the effectiveness of the service(s) and the user's continued satisfaction with the service(s) and the personal assistant.

The ISP should be developed through a highly interactive process involving the PAS user and/or their legally appointed representative, and/or an advocate selected by the user and/or their legally appointed representative, the service provider(s), and the service coordinator. The PAS user may elect to be the service coordinator. The knowledge, life experiences, views and desires of the PAS user or their legally appointed representative, and/or advocate should be actively solicited and given full consideration throughout the assessment and ISP process.

When necessary, the ISP should be coordinated with other service clans such as the IFSP and IWRP. All efforts must be made to protect the confidentiality and privacy rights of PAS users.

The ISP should be reviewed and updated at least annually in an efficient, non-obtrusive, and economic manner, or at the request of the individual or their legally appointed representative, and/or advocate to reflect the needs of the PAS user. When circumstances require, the ISP shall be amended so that additional services shall be provided to address the changing needs of the user. (e.g. injury, exacerbation of disability, illness or death of family member who provided PAS.) Disagreements arising from negotiations in the ISP development process should be resolved according to procedures described in the section on due process. PAS services should continue during any appeals.

State planning and PAS systems design

Based upon the key concepts, principles and assumptions described in this paper, the minimum State planning and PAS systems design requirements should be as follows:

Lead State Agency: A lead state agency should be designated by the governor or legislature to plan, develop, administer and coordinate and to accept full accountability of PAS programs, services and activities in each State. The legislation should make clear that this agency cannot be a medical/health agency. The responsibilities of the lead state agency should include:

- designating a single point of entry (SPE) in communities;

- maintaining a statewide (V/TDD) 1-800 PAS INFO Line to provide up-to-date date information on PAS services and refer individuals to the SPE and other resources in their communities;

- establishing procedures for program operations, including a process to enable funds to go directly to PAS users to hire their own personal assistants;

- creating incentives for private sector involvement, such as: comparable pay and benefits, unless state can justify otherwise; preference for private providers which are user controlled; assistance to small private providers (e.g., in pooling to negotiate for goods and benefits); assuring uniform availability of PAS services throughout the state;

- preparing, in cooperation with the planning and advisory board, the State plan; and,

- establishing management assistance programs through contracts or other mechanisms to process FICA, tax withholding and other deductions of personal assistants.

Funds should be made available to pay for the agency's administrative costs associated with carrying out these and other related responsibilities.

Single Point of Entry

The lead state agency should be able to designate/contract out with other public or private agencies to carry out the functions of a Single Point of Entry for PAS by 1) catchment area, 2) set population(s) and/or 3) set services.

To be designated by the state as a Single Point of Entry for applying for and accessing personal assistance services, an agency should be required to demonstrate the capacity and accept the responsibility to serve all those who need such services as well as to respond to multiple points of referrals.

Specific functions of the entry point would include: intake; eligibility determination; conducting needs assessment/ service specificity; determining scope of services (hours, duration, etc.); referral to providers; contracting for services; outreach initiatives, particularly to potentially eligible individuals.

Such agencies also must be involved in interagency coordination, quality assurance, due process and all other aspects of PAS service delivery.

In order to be designated the single point of entry, an agency shall have a consumer controlled advisory council to guide it's activities and services. This council should be composed of 50%+ of PAS users and their families or representatives and broadly representative of the disability community.

Systems Change Incentives

The legislation should require that each State establish a state policy board on personal assistance services, which should be:

- composed of at least 60% of PAS users and their families or representatives (2/3 are PAS users and families or minor children, 1/3 are families or representatives or individuals not represented above)

- broadly representative of the disability community

- geographically representative

- include members from affected state and local agencies

- appointed by governor, with advice/nominations from the disability community independent of the lead agency

The policy board should jointly develop the state plan with the state agency, and oversee implementation as well. It should be a staffed body and preference should be given to the hiring of qualified (cross disability trained) users of personal assistance services. Additionally, non-governmental members of the board who are not otherwise paid to perform duties associated with the board, should be reimbursed on a per diem basis. The per diem should include the salary, travel and other expenses of the member and those of their personal assistant(s) if applicable.

The PAS policy board also should take the lead role, in cooperation with the single state agency, in developing user-friendly policies that:

- ensure widespread cross disability outreach and involvement in all aspects of the design, delivery and evaluation of PAS programs, services and activities, including training, throughout the State

- create and require the use of user satisfaction standards and life outcome measures in all aspects of the State's PAS Quality Assurance efforts

- prohibit the denial of services based on an applicant or PAS user's type or level of disability

- promote cost-effective administration and other cost savings in the design, delivery and evaluation of PAS services

- foster decision-making by PAS users in the design and delivery of PAS services

- create and foster the use of a PAS conflict resolution process

- promote the pooling of purchased goods and benefits

- maximize private sector utilization

- create, foster and assess the use of a direct subsidy option to provide PAS users the choice of purchasing their personal assistance services directly

- eliminate or reduce the need for segregated, facility based care

- require outreach efforts by Single Point of Entry agencies to ICP/XR's and nursing home facilities to ascertain need/availability of personal assistance services throughout the State

The PAS legislation should authorize the use of higher federal matching share as an incentive to eliminate or reduce the use of segregated, facility based care and instead provide individuals in segregated facilities with needed personal assistance services in their own homes and communities. The legislation should consider size of the institution and length of stay in regards to this provision. It also should require that each State PAS planning and advisory board hold a minimum number of meetings per year at a variety of convenient and accessible sites throughout the State.

Public participation, especially by PAS users and their families or representatives, in the workings of the board is essential. It should, therefore, be widely encouraged and a required part of each board meeting. Adequate public notice should be given for each meeting in a variety of accessible formats.

State Planning

The PAS legislation should require that each state develop a consumer-driven long-range 5 year plan, updated annually, on all aspects of the design, delivery, evaluation and future directions of PAS programs, services and activities in the State.

The single state agency should be responsible for preparing the State plan. Each state plan shall specify the timelines for its implementation. The public, particularly PAS users and their families, must be involved in the development and revision of the plan. Feedback from quality assessment and consumer satisfaction assurance activities must be used in revising the plan annually.

Each plan should clearly describe and provide adequate assurances that the State has the sufficient capacity, user-friendly policies and practices in place to ensure uniform availability of PAS services throughout the state by providing for: individualized services; cross disability coverage; life span coverage; statewide coverage; recruitment, referral, outreach and training systems; staffing and staff training; public participation; quality assurance.

Each State plan should specify how funds may be spent and further delineate lines of responsibilities regarding all aspects of the design, delivery and evaluation of PAS programs, services and activities.

Training on personal assistance

Under a comprehensive federal Personal Assistance Services statute, Federal financial assistance for PAS skills training should be made available by the State lead agency. PAS users, and where appropriate, their legally appointed representatives and advocates should be informed of, and provided such value- and competency-based training on PAS upon request. PAS users, their families and advocates should be involved in every aspect of training, including the design of the training curriculum, training materials, and the delivery of training. The policy board should review these training programs.

Towards this end, States should provide assurances that, to the maximum extent possible, all such training is:

- reflective of and responsive to the preferences and expressed interests of individuals with disabilities;
- developed, designed, delivered and evaluated by qualified PAS users; and,
- provided by disability consumer organizations and other qualified agencies.

Training for users of personal assistance services

States should make available to each PAS user training in their roles, responsibilities, and rights as a manager and/or consumer of personal assistance services. The need for training should be described in and carried out as part of the user's Individualized Service Plan.

The training shall be provided in the primary language of the user. All materials shall be provided in an accessible format when needed.

Specifically, PAS management training should be made available to users to assist them to acquire and improve their skills in regards to scheduling, training, supervising, compensating, evaluating, disciplining, and discharging PAS workers. Similarly training also should be made available to users in quality assurance to assist them in defining quality life and service outcomes, evaluating the quality of the services, recognizing inappropriate and poor quality services, including neglect and abuse, and how to use the appeals process. All such training should be provided in the media, language, materials, and format which is best suited to meet the consumer's needs. A PAS user may waive their right to receive such training.

If an adult PAS user cannot fully benefit from this trainings or the user so directs, his/her legally appointed representative(s) and advocate(s) should be informed of and provided training upon request. When a child requires PAS, the personal assistant should be responsible to the parent/guardian until the child reaches the age of majority. Such parents should be informed of and provided upon request, training designed to assist the child, with his/her assistant, to assume increased freedom, responsibility, and choice as she grows.

Training for individuals who provide personal assistance

An introductory orientation to PAS should be required for all individuals who provide personal assistance unless waived by the individual with a disability or the individuals who provides personal assistance has demonstrated experience. The orientation should emphasize to the individual who provides personal assistance that their purpose is to assist an individual with a disability to achieve self-determined goals.

This orientation for individuals who provide personal assistance should be value-baked and include information on: disability as a natural human condition; the philosophy of independent living; the principles of community integration; the dignity of risk; the role, rights, and responsibilities of PAS users; the role, rights, and responsibilities of personal assistants; and, the appeals process.

The training and orientation shall be provided in the primary language of the provider. All materials shall be provided in an accessible format when needed.

States should make available additional training on an individualized, as needed basis. The need for such training of an individual who provides personal assistance should be described in and carried out as part of the Individualized Service Plan. Federal legislation should further specify that a PAS user may require that personal

assistance providers be trained in the skills required to meet the services called for in the ISP. Moreover, the PAS legislation should require States to review, revise and waive nurse practice act requirements which unnecessarily hinder personal assistants from being trained and/or carrying out their responsibilities.

PAS provider compensation and related issues

In order to assure high quality in services, a federal PAS statute should require that personal assistants are meaningfully compensated for their labors and receive fringe benefits comparable to those available to other paraprofessionals in similar fields.

The compensation of personal assistants should be meaningfully related to such factors as:

- the required skill level of the personal assistant as specified in the person's ISP;
- the education and training required of the personal assistant;
- the geographic area and local labor pay rates;
- the duties and skills required by the ISP;
- the length of service/experience of the personal assistant; and,
- night and weekend shift differentials.

Compensation for full-time assistants should include traditional employee benefits, e.g., health insurance; sick and annual leave; FICA; workers' compensation and unemployment insurance. In addition, assistants should have liability insurance coverage. Benefits for part-time workers should be prorated to their hours worked. States should be required to establish mechanisms (e.g., benefits pools) for fringe benefits to assist individual providers and small employers to acquire benefits at a reasonable cost. The legislation should encourage States to provide additional benefits to PAS providers which are available to state employees, including: Retirement; Professional development; Employee credit unions; and, Disability Insurance.

The legislation should also provide incentives to the States to investigate, develop and implement promising and innovative approaches for:

- determining the compensation rate for ISPs requiring different levels of skills, experiences and training;
- encouraging PAS users and their personal assistants to develop and maintain positive, productive and enduring working relationships as a means of preventing abuse and neglect, high turnover rates and burnout;
- enhancing career opportunities for personal assistants in ways which encourage individuals to remain in the PAS field.

For PAS users who rely on management assistance, recruitment, screening, and referral services, there should be up-front criminal background checks and job-interview screening to determine the general qualifications of those seeking personal assistance positions. PAS users should be able to assume that basic quality measures have been met, including that the applicant or service provider has been screened and that he/she is, in fact, qualified to do the job. Finally, States should establish mechanisms and funding resources to develop and maintain a cadre of trained personal assistants who can provide PAS to users on both on-going and emergency basis.

Quality assurance

The federal PAS statute should include requirements for States to develop and implement a system of quality assurance to foster quality and excellence in every aspect of the design, delivery and evaluation of user responsive personal assistance services. Such a system of quality assurance should be premised upon the following major assumptions and guiding principles:

1. Quality is defined best in terms of the individual, based on desired life outcomes that the person, their legal representative and/or advocate, recognize as important.
2. These outcomes can include integration into one's community, participation in desired activities, increased mobility, more efficient daily living, enhanced communication, general well-being, self-direction, productivity, employment, or an increase in social skills. (Note: An individual need not demonstrate an ability to achieve a particular life outcome to recognize it as important or to work towards it.)
3. It is impossible to ensure a total absence of abuse. However, abuse, neglect and exploitation of individuals with disabilities can be significantly minimized and prevented by: promoting quality services; fostering maximum self-determination; recognizing the dignity of risk-taking; ensuring that safeguards are in place to identify

and respond immediately and effectively to instances of abuse, neglect or exploitation; screening of PAS providers; providing information on abuse, neglect and exploitation as part of the orientation; training PAS providers: and training PAS users as needed.

State PAS Quality Assurance systems should develop and put in place user-friendly policies and practices that:

- affirm that PAS users must drive all aspects of the process;
- ensure that QA is recognized as a prime consideration in every step involving the requesting, offering and providing of PAS;
- affirm that PAS users must be assumed to be able to be independent,¹ unless demonstrated otherwise;
- recognize QA as an on-going individualized and comprehensive assessment of services in relation to the desired outcomes of the PAS user or their legally appointed representative, and/or advocate;
- ensure the person is satisfied with the quality of the service(s) provided;
- take a pro-active approach, anticipate, respond to and solve problems and challenges in a manner that does not go beyond the need of the individual for support;
- provide for a system of "early warning signals" for identifying and remedying current or potential problems (e.g., excessive staff turnover);
- ensure that each individual's ISP has a QA component in it specifying the type/level of QA support and assistance to be in place (e.g., drop-in visits, natural supports and citizen advocacy services);
- ensure that if problems are discovered, it triggers a remedy and, if warranted, a re-examination of the QA component of the individual's ISP;
- provide for background checks and job-interview screens to determine the general qualifications of those seeking personal assistant positions;
- ensure that the service provided meets measurable standards of quality and apply to family and non-family providers of PAS, as appropriate;
- provide incentives for best practices and sanctions for undesirable practice; and,
- provide for enhanced QA support and assistance to people who are at-risk or particularly vulnerable to abuse, neglect or exploitation.

It is critical that PAS users be given the support they need to gain, maintain and improve competencies and skills required to exert greater control over their own lives. In many instances, this should include providing management training or support to assist a person in having as much effective control over services and personnel as possible. Whenever necessary, assistance should be provided to enable an individual to be more self-directing and/or to assist him/her to maximize his/her interaction with his/her personal assistant. If an user requires or requests an advocate, the primary role of that advocate should be to elicit and advocate for the views, choices and preferences of the individual with a disability.

The State system must have varying levels of quality assurance support because individual abilities and preferences regarding quality will vary. Available support levels should be sensitive and responsive to factors such as the nature/level of one's disability; life experiences; individual needs and preferences; communications abilities; willingness, interest or capacity in playing a significant role in assessing quality; and those supports necessary to enable a quality assurance role.

Moreover, each State's PAS QA system should provide for independent assessments of quality and consumer satisfaction. PAS users, their families and advocates should be involved in every aspect of designing and carrying out these assessments. Such assessments should be made by persons or organizations independent of the service provider or the state. Each independent assessment should include a review of life outcome measures and the review of quality must be linked to the outcomes. The timing of such assessments may vary based on individual need, but at mini-

¹ PLEASE NOTE: This use of this term is consistent with the definition of "independent living" developed by the National Council on Disability as being "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (National Policy for Persons with Disabilities, 1983). In its 1986 Report, *Toward Independence*, the NCD further comments that: "Living independently includes managing one's affairs, participating in the day-to-day life of the community in a manner of one's own choosing, fulfilling a range of social roles including productive work, and making decisions that lead to self-determination. Community-based services that promote such independence for Americans with disabilities constitute one of the most promising service delivery strategies for our Nation." p.43.

mum, must be annual or semi-annual as indicated in the ISP. Assessments also must include solicitation of the consumer's suggestions for improvements. Additionally, in-home assessments of service delivery must focus on the service being delivered.

Finally, in regards to State Planning requirements, each State's plan should clearly describe the ways in which PAS quality assurance program will fit into the overall system while still retaining its independence. The State Plan also should define and describe what role(s) the Protection and Advocacy system, the Independent Living Centers, the Developmental Disabilities Planning Council, Area Agencies on Aging, child protective services and other public/private entities should play in PAS QA efforts. Moreover, States should be required to use feedback from quality assessment and user satisfaction surveys in revising the plan annually. This approach should be flexible enough to encourage best practices to develop.

Assuring rights protection and due process

The following are the basic rights protection and due process procedures that should be established under a federal PAS statute:

An Established Appeals Process: The PAS legislation should establish a basic appeals process similar to those in IDEA and the Rehabilitation Act which would be used to resolve any disputes between an individual with a disability and any State entity, program or individual providing personal assistance services to the person. While both IDEA and the Rehab Act include procedural safeguards intended to ensure the impartiality of the hearing process, the actual implementation of these provisions often falls short of the overall intent. Hence, the appeals process adopted for PAS should include the current procedural safeguards found in these two laws and some additional safeguards as well. Specifically, PAS legislation should include the following provisions.

1. **Purpose of the Appeals Process**—The legislation should clearly state the purpose for establishing the appeals process.

2. **Informing Affected Individuals**—All persons seeking or receiving services funded under the legislation must be informed of the procedural safeguards available under it. This notice should include the names and addresses of the individuals or agencies with whom appeals may be filed. It also should include the name(s) and address(es) of the Protection and Advocacy System(s) where they may obtain advocacy or legal services and/or assistance. This information must be provided during all PAS orientation, during the development of the ISP and at each ISP review.

3. **Notification of Change in Service Status** individuals receiving services must be given a timely and adequate written notice prior to changing, reducing or terminating services. Such notice must explain the reason for the change and an estimate of the date that the change will occur.

4. **Issues an Applicant or PAS User Can Appeal**—The legislation should identify the actions, issues, and circumstances which an individual can appeal.

5. **Informal Review**—It should permit the development of an informal and voluntary administrative review process if it is likely to result in a timely resolution of disagreements in particular instances. However, it should further make clear that this process may not be used as a means to delay a formal hearing unless the parties agree to do so. The choice of whether to use this approach needs to rest with the applicant or PAS user.

6. **Mediation/Negotiation**—The legislation should encourage but not mandate that an attempt be made to mediate or negotiate a resolution between the individual with a disability and any State entity, program or individual providing personal assistance services to the person. Decisions affecting when and whether to mediate a dispute shall be made solely by the PAS user or other authorized representative.

7. **The Minimum Formal Review Procedures**—The legislation also should clearly delineate the minimum requirements that must be met by any formal review process that is used to resolve conflicts which arise between individuals with disabilities and the programs that provide them personal assistance services funded under it.

These minimum requirements should: mandate the use of impartial hearing officers in any formal review procedures; establish minimum requirements for serving as an impartial hearing officer; and, ensure that a hearing is held to investigate and resolve any conflict involving the requesting, offering and providing of personal assistance services, within 45 days of a request by an applicant or PAS user.

The rights protection and due process section should further direct States to develop and put in place user-friendly policies and practices that: specify that an applicant or PAS user or, if appropriate, the individual's parent, guardian, or advocate, must be afforded an opportunity to present evidence, information, and witnesses to the impartial hearing officer; assure an applicant or PAS user of their right to be represented by counsel or another advocate, and to examine all witnesses and other

relevant sources of information and evidence; and, prohibit the introduction of any evidence at the hearing that has not been disclosed to the individual with a disability at least five days before the hearing.

The impartial hearing officer should be required to make a decision based on the provisions of the law, governing regulations, and, if applicable, the State Plan for PAS, and provide the individual with a disability or, if appropriate, the individual's parent, guardian, or other representative, and to the Director of the service providing agency a full written report of the findings and grounds for the decision within 30 days of the completion of the hearing. The individual with a disability must be provided the final decision of the impartial hearing officer in an accessible format. Upon request, the individual must be provided with a record of the hearing in an accessible format.

Similarly, the rights protection and due process section should make clear that any accommodations necessary to ensure the full participation of the individual with a disability or, if appropriate, a parent, guardian, or other representative at any stage of the due process procedures should be provided at public expense. This would include such things as ASL interpreters or interpreters fluent in the primary language of the individual.

In addition, each hearing involving oral arguments must be conducted at a time and place which is reasonably convenient to the parties involved. The impartial hearing procedures should provide for reasonable time extensions for good cause shown at the request of one or both parties.

8. Conditions for Continuing Services Pending an Informal Review or a Formal Hearing. All services called for in an user's ISP shall be provided to the individual throughout the appeals process.

9. Private Right of Action—Any party aggrieved by the findings and decision made by an impartial hearing officer should have the right to bring a civil action in any state court of competent jurisdiction or in any district court of the United States within four months of the date of the issuance of the hearing officer's written decision.

10. Utilizing An Existing Protection and Advocacy System to Resolve Disputes—The legislation should also provide incentives to States to develop and implement innovative approaches utilizing existing P&A systems in investigating and resolving disputes involving the requesting, offering or providing of personal assistance services.

APPENDIX 2

DEFINITION OF MENTAL RETARDATION

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

APPLICATION OF THE DEFINITION

The following four assumptions are essential to the application of the definition:

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioral factors;
2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports;
3. Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities; and
4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

SOURCE: Mental Retardation: Definition, Classification, and Systems of Supports. 9th Edition—American Association on Mental Retardation.

APPENDIX 3

DISABILITY/SENIOR LONG TERM SERVICES APPROACH

Eligibility criteria

1. All persons who are eligible for SSI because of disability will be presumptively eligible for the program. This does not mean that there is a presumptive entitlement to services. Each person will be assessed for their service needs through the regular assessment process.
2. Persons requiring human assistance with 3 or more ADLs.
3. Persons who because of cognitive or other mental impairments
 - (a) require substantial supervision; or
 - (b) require substantial assistance to perform four out of seven IADLs (taking medications, managing money, meal preparation, shopping, light housework, using the telephone or getting around the community); or
 - (c) who have an equivalent level of impairment resulting from a combination of the need for supervision, the need for assistance in performing ADLs and IADLs, and other relevant factors, such as medical or health needs.
4. Children who are unable to function independently, appropriately and (or) effectively in an age appropriate manner (SSI criteria).
5. The Secretary will have the discretion to develop eligibility criteria to accommodate the needs of individuals with extraordinary circumstances, and individuals with a comparable level of impairment resulting from factors such as: a) a combination of the need for assistance in performing ADLs and IADLs, b) a combination of cognitive/mental and physical impairments, and c) and other relevant factors such as unstable medical conditions or sensory disabilities, which are not captured by standard eligibility criteria.

APPENDIX 4

FEATURES OF CONSUMER PARTICIPATION, QUALITY ASSURANCE, AND STATE SYSTEMS DESIGN

The following features of consumer participation, quality assurance, and state systems design are offered for use with various options for a long term services and supports system. The features may need alteration depending on the context in which the key elements are used. These key features should be considered in the light of previous discussions with the Working Group members regarding basic principles and philosophies for long term services for people with disabilities of all ages (e.g., consumer-focused, consumer-driven, community services, promotion of independence and community integration, etc.)

Systems Planning

1. Each Governor must establish an independent state policy board on LTS which includes a majority of consumers and their representatives and which is representative of the broad disability community (cross-disability representation) including people of all ages. The board should also include representatives of key state agencies, other governmental representatives, providers, and the general public. The board must be independent of other state agencies, with adequate staffing and control of its own budget for carrying out its duties. The disability community must have the right to nominate potential members of the board and the Governor must explain any failure to appoint such nominees as well as find similarly qualified people to serve instead. (See the Rehabilitation Act for a precedent.)
2. Each state should be required to develop a consumer-driven long-range strategic plan on all aspects of the design, delivery, evaluation and future directions of the LTS programs, services and activities in the State. The plan should be a five-year plan and should be updated annually. The plan should cover all LTS programs in the state (including community and institutional services) and indicate how the state will assure that the needs of all the diverse groups of eligible people will be adequately addressed. The plan should be based on the valued outcomes for consumers as defined in the authorizing legislation and describe how the state will increase and/or redirect resources to the community. The plan should further describe the extent and ways in which all long term services and service systems, including existing ones, will seek to promote the policy values of the Americans with Disabilities Act which call for the full integration and inclusion of Americans with disabilities of all ages into every aspect of American community life.

3. A state's long-range strategic plan should be prepared in consultation with the State Policy Board. The plan should be approved by the state, with modifications as necessary and with written explanations of any rejections or changes in the plan. The plan should specify how funds will be spent, and delineate lines of responsibilities regarding all aspects of the design, delivery and evaluation of LTS programs, services and activities. The plan should evaluate and implement strategies to meet the needs of unserved or underserved groups and geographic areas of the state. Feedback from quality assessment and consumer satisfaction assurance activities must be used in preparing and updating the plan annually. If a national long term services and supports program must be phased in, the plan must specify the proposed phase-in of eligibility and priority order, if any, of people to be served.

4. A state's long-range strategic plan should include implementation timelines.

5. The public, particularly LTS users and their families, must be afforded an opportunity to be involved in the development and revision of the plan, through public hearings and other procedures, as well as the monitoring and evaluation of state plan implementation. The plan should be widely disseminated throughout the state in accessible formats so that availability is assured for consumers, families, advocates, and organizations serving people with disabilities. The state shall take into account and respond to significant suggestions from the public.

Systems Administration and Coordination

6. States should be responsible for the administration and coordination of all the long term services programs. The state plan should specify how the programs will be administered and the policies and procedures for assuring coordination of all long-term services and service systems within the state, including existing state/local aging agencies, mental health and mental retardation/developmental disability agencies, children with special health care needs agencies, and any other specialized agencies which provide long-term services as well as coordination with other relevant state agencies on education, health care, and rehabilitation.

7. The delivery of LTS should be built upon the existing state and local LTS infrastructure, with restructuring or adjustments, as necessary, to meet the needs of groups previously unserved or underserved.

8. Federal legislation should define the administrative parameters for the new program.

Services

9. Because there is an enormous variation among the states in the way LTS are organized and delivered, federal legislation must contain clear specifications regarding desired service outcomes, while leaving the states sufficient latitude to determine the most appropriate ways of achieving these outcomes given their own unique situations and service delivery infrastructure.

10. Every eligible person must have an Individual Service Plan (ISP) (for children, a Family Service Plan) which is to be developed jointly by the service manager/coordinator and the recipient of services. The ISP/FSP should begin with the individual's self-assessment of his or her needs (for children, the family's needs) to the maximum extent possible. When appropriate, the individual's representative/guardian should also be involved in the assessment and decision-making process.

Quality Assurance

11. A state's long-range strategic plan should establish and describe a comprehensive quality assurance system that includes the following elements:

a. Appropriate quality assurance measures must be implemented statewide and at the local level. Such measures should foster quality and excellence in every aspect of the design, provision, and evaluation of long-term services and supports.

b. Consumers and families should have a primary role in defining and assessing quality of services.

c. Quality assurance systems should have safeguards in place to identify and respond immediately and effectively to instances of abuse, neglect, and exploitation.

d. Individualized quality assurance provisions should be built into each ISP/FSP and be tailored to each person's/family's need and preferences regarding the delivery of LTS. This approach will help to target resources to those who most need substantial quality oversight protection while not imposing extensive protection mechanisms on those consumers who neither need nor want such oversight.

e. There must be specific policies and procedures to protect the privacy and confidentiality of program participants.

f. Independent periodic assessments of quality and consumer satisfaction should be conducted at least annually with appropriate consumer protections for confidentiality. Such assessments should address whether individual's/family's goals in the system are being met as well as whether the state is meeting requirements for quality assurance.

g. There should be federal guidelines for the inclusion of timely due process procedures in the state plan.

12. Individual protections should be in place, including grievance procedures to handle complaints or disputes; protection of an individual's current services while complaints are being addressed (see IDEA for precedent); a permissive alternative dispute resolution process; and a private right of action with availability of attorneys fees.

13. There should be a clear federal role for ensuring quality of services with enforcement mechanisms to ensure state and provider compliance.

a. The federal government should develop minimum requirements for protecting the health and safety of consumers and for preventing abuse or exploitation and should monitor the states' performance in maintaining such standards; Such standards should be developed in a manner to maintain maximum flexibility for serving individual needs and should avoid micro-managing of services; standards would be different for different settings.

b. Federal reviews should also address outcome from the perspective of consumers and strive to avoid "paper compliance" results. Such reviews should consider whether individual consumer needs are being met by the system and should address the actual involvement of the consumer in decisions regarding individualized/family services and quality assurance mechanisms.

c. Federal review should address the states' compliance with its own quality assurance system and with implementation of its state plan. Federal review should also address the extent of a state's responsiveness to consumer input regarding the system as a whole and the responsiveness of the annual updating of the five-year plan.

d. The federal government should have enforcement mechanisms to ensure compliance. Such mechanisms should allow for intermediate sanctions as well as complete "decertification".

Senator WOFFORD. Max Richtman, welcome.

Mr. RICHTMAN. Mr. Chairman, I am pleased to be here today to provide the National Committee's initial reaction to the administration's long-term care proposal.

Overall, the National Committee applauds the administration for introducing a health care plan which guarantees health insurance for all Americans and provides important new benefits for seniors, including long-term care.

The National Committee, however, does have reservations about the overall equity of the financing. The community-based long-term care program for the severely disabled of all ages and all incomes constitutes an important step toward full protection against the financial devastation of long-term care. Without long-term care, the National Committee could not support health care reform. All States, however, must be required to offer this program and provide improved asset protection for Medicaid nursing home residents.

In addition to discussing the administration's proposal for a new home and community-based program, and improvements in the Medicaid nursing home benefit, I would also like to discuss regulation of private long-term care insurance and Senator Kennedy's Life Care Act.

The National Committee supports State flexibility in the administration's proposal because many States already have innovative home and community-based long-term care initiatives. That has been discussed earlier today. New Federal dollars can build on these well-developed programs. The programs should not be so

flexible, however, that States can choose whether to participate. That is a concern of the National Committee.

Also, we are uncomfortable with the conditional connection between the new benefits and savings in Medicare. We hope that Congress is committed enough to this benefit even if the full savings do not materialize. Relying on other funding sources for at least some of the cost would be more fair.

The National Committee believes copays for home and community-based services of no more than 25 percent should be applied while still protecting the poor from out-of-pocket costs. A copay by income, we believe, would be an administrative nightmare, and a 40 percent copay, we believe is excessive.

While the intent of the legislation clearly is for States to offer a variety of long-term care services, it only mandates personal assistance. Some States may therefore not offer anything else and thereby eliminate choice. The National Committee strongly agrees with the points and testimony given by the Alzheimer's Association on this issue.

In regard to the Medicaid improvements, the National Committee is disappointed that States will only be given the option to raise the asset limit from \$2,000 to \$12,000 rather than be required to raise it. This is a very important issue, as the Chairman pointed out earlier this morning.

We are also disappointed to see that the nursing home needs allowance in the final plan will only be raised from \$30 to \$70. The needs allowance is all that the resident has to spend on personal items. We believe \$70 is not adequate.

The National Committee is pleased, however, that the medically needy provision will be required in all States. This is good news for National Committee members and many others whose incomes are just a few dollars above their State-set limits, thereby preventing them from qualifying for Medicaid nursing home benefits.

The administration's proposal says nothing about the need for increased financing required to improve care in nursing homes. An adequate minimum staffing standard is needed, as well as a mechanism to assure appropriate funds are used for direct care.

Long-term care private insurance continues to be an important piece of the long-term care puzzle. Federal regulations similar to medigap regulations, however, are needed to protect the consumer. Without reforms, many will end up with a false sense of security. Both the administration's proposal and the chairman's Long-Term Care Insurance Improvement and Accountability Act contain important provisions such as mandatory nonforfeiture, simplification dispute resolution and counseling. The National Committee supported the medigap reforms in the last Congress, and we support reforms in long-term care insurance also.

Senator Kennedy's Life Care legislation also fills an important gap in protection. A middle-class person can voluntarily pay for this insurance with the security that life savings will be protected because the benefit, which is limited to \$30,000, \$60,000, or \$90,000, is coordinated with Medicaid nursing home benefits. Because this insurance would have no underwriting, it provides access to long-term care insurance that many would not be able to find in the private sector.

In conclusion, Mr. Chairman, the National Committee's 1992 member survey overwhelmingly confirmed the desire for a comprehensive long-term care public program, including respite care for exhausted family caregivers. However, when given the choice between a nursing home benefit or a home care benefit of equal value, respondents chose home care by more than eight to one.

The administration's proposal for a home and community-based long-term care program is a first step and follows our members' preferences. The chairman's legislation on voluntary nursing home coverage complements the administration's home and community-based care proposal. Seen together, these two programs could help ease the fear of becoming disabled and dependent and would hasten the day when this country has a comprehensive long-term care program.

We look forward to working with you and the committee during this coming year on these issues.

Thank you.

[The prepared statement of Mr. Richtman follows:]

PREPARED STATEMENT OF MAX RICHTMAN

Mr. Chairman, members of the Committee, I am Max Richtman, Executive Vice-President of the National Committee to Preserve Social Security and Medicare. I am pleased to be here today to provide our initial reaction to the Administration's and the Chairman's long-term care proposals.

The Administration's proposal to provide community based long-term care for the severely disabled of all ages and all incomes constitutes an important step towards full protection against the financial devastation of long-term care. Without long-term care, the National Committee cannot support health care reform.

All states, however, must be required to offer this program, and to provide improved asset protection for Medicaid nursing home residents. We also believe that the long-term care program should be implemented before 2003.

Overall, the National Committee applauds the Administration for introducing a health care plan which guarantees health insurance for all Americans. While we recognize that the plan also provides important new benefits for seniors-including long-term care, which is the subject of these hearings, the National Committee has reservations about the overall equity of the financing.

Today, I want to comment on three main aspects of long-term care: The Administration's home and community-based program and Medicaid nursing home improvements; Private long-term care insurance regulations; and The Chairman's Life Care Act.

Community-based long-term care

The National Committee supports state flexibility in the Administration's long-term care proposal because many states already have innovative initiatives and new federal dollars can build on these well-developed programs. However, we are concerned that there is no requirement for states to apply for the new program nor to spend up to the state maximum allowed under the federal program. The federal match of between 75 and 95 percent should be very attractive, but, undoubtedly, some states will be concerned about funding even the 5 to 25 percent of the cost. Or they may be concerned about an open-ended obligation to serve the disabled in spite of legislative language clearly states that this benefit is not an entitlement. The legislation which clearly states that there is no individual entitlement to benefits—a provision we are willing to accept—but we will insist that a state-mandated, fully-funded, community-based long-term care program be available in all states.

We are uncomfortable with the conditional connection between the new benefits and savings in Medicare. There is no reason that a benefit for all Americans should be conditional on Medicare savings, some of which will increase out-of-pocket costs to Medicare beneficiaries. Even if it is possible to realize all the proposed savings—and that is a questionable assumption—these savings could have been applied to making Medicare benefits as good as the standard benefit package. We at least hope that Congress is committed to this benefit, even if the full savings do not materialize. Relying on other funding sources for some of the cost would be more fair.

Co-Payment. The National Committee believes co-payments for home and community-based services of no more than 25 percent could be applied while still protecting the poor from out-of-pocket costs. A co-payment by income, would be an administrative nightmare and 40 percent co-payment is excessive. With a few hours of home care and several days a week of adult day care, for example, the disabled person could end up paying \$400-\$480 in co-payment per month. These expenses would be only partially tax deductible. A severely disabled person may need to supplement the public benefit with private services because they need more hours of care than the program can provide. The disabled individual would have to pay for these additional services out-of-pocket unless they had insurance. Therefore, their total out-of-pocket health care costs could be a high percentage of their total income. No other program—public or private—requires such a high co-payment with the exception of the mental health benefit under Medicare. The Pepper Commission recommended a 20 percent co-payment. If there must be a co-payment, the National Committee would limit it to no more than 25 percent.

Consumer empowerment. The National Committee welcomes the strong consumer involvement in the development of the state plans and the emphasis on self-determination in the home and community-based benefit. The plan calls for the disabled to provide, through an advisory council, substantial input into the development of the state plan. It also intends for states to allow consumers of long-term care benefits considerable flexibility through vouchers or cash payment. Consumers could hire their own attendant or buy their own services. They could even pay a family caregiver to take care of them. A cash payment could provide an important sense of independence rather than the guilt that often comes with being a burden to one's family. States should still assure that caregivers are trained and should periodically have certified care managers assess the care.

Choice of services. While the intent of the legislation clearly is for states to offer a variety of long-term care services, it only mandates personal assistance. Some states may therefore limit benefits to the minimum requirement and thereby eliminate consumer choice. A program rigidly limited to personal assistance cannot serve the differing needs of severely disabled individuals. Adult day care, for example, can provide family respite, rehabilitation and socialization. Transportation should be covered because seniors could lose their independence without it. The National Committee would prefer to see more services mandated as feasible depending on geographic location.

Federal Advisory Group. The National Committee agrees with the proposal to create a federal advisory group, and we recommend that it be modeled after the Physician Payment Review and the Prospective Payment Review Commissions. It should have a staff capable of performing the background work necessary for the advisory group to make decisions and carry out its advisory responsibilities. This panel of experts should begin to make recommendations on the myriad of issues related to long-term care. For example, the development of guidelines or standards for care management, adult day care and other services; development of a standardized assessment tool that would be compatible with the assessment tool now used in nursing homes; development of a sensible payment system for different levels of care or case mix; the analysis of the infrastructure of long-term care and the identification and promulgation of best practice models around the country; best ways to assure quality of care; and the development of standardized data systems for collecting data. A central entity is needed at the federal level to move the country towards better integration not only of long-term care services, but acute and long-term care services.

Asset Protection. The National Committee is truly disappointed that states will only be given the option to raise the asset limit from \$2,000 to \$12,000. The National Committee realizes the strain many states are under regarding Medicaid mandates, and given the additional cost to states of raising the asset limit, we are concerned that many states will retain the \$2,000 limit. The National Committee frankly regrets that the President's plan would not do more for nursing home residents. For example, the Pepper Commission recommended that Medicaid residents be able to protect \$30,000 in assets. Raising the asset protection to \$12,000 is still a small amount. We recommend that it be a minimum of \$12,000 and it be mandated.

Needs Allowance. In the draft proposal, the Medicaid personal needs allowance for nursing home residents was raised from a meager \$30 to \$100 a month. National Committee is disappointed to see that the nursing home needs allowance in the final plan will only be raised to \$70. This amount is only a little over two dollars a day in spending money. The needs allowance is all that the resident has to spend on personal items. In a few places such as Washington, D.C., nursing home residents who already receive a \$70 needs allowance, will not have an increase. There

will be additional administrative burdens due to the fact that the federal government will pay the state 100 percent of the difference between what the state currently allows and the \$70 while maintaining the standard Medicaid match for the amount up to \$30.

Medically needy. The National Committee is pleased that the medically needy provision will be required in all states. This means that nursing homes would no longer be a closed option for people in some states whose income is above the state requirement for Medicaid eligibility even though they cannot afford the full cost of nursing home care. With this change, as long as the disabled person's assets are no more than the maximum level, he or she can qualify to enter a nursing home. This will be good news for the National Committee members whose incomes are just a few dollars above state limits.

Nursing Home Quality. While the Administration's proposal provides small improvements to Medicaid nursing home coverage, it says nothing about the need for increased financing required to improve care in nursing homes. Both licensed nurse and nurse aide staffing is inadequate in nursing homes across the country. The Pepper Commission recognized that "access to quality care would require higher rates than many Medicaid programs now require." An adequate minimum staffing standard is needed as well as a mechanism to assure appropriate funds are used for direct care.

In addition, we want to call attention to the fact that current federal regulations do not assure protection of the Nursing Home Reform Act to private pay residents. These protections should be extended to all nursing home residents living in Medicare and Medicaid certified facilities.

Private long-term care insurance

Long-term care insurance continues to be an important piece of the long-term care puzzle even with a new home and community-based program for the severely disabled. People may need to supplement public services or seek protection against nursing home costs.

The National Committee supported federal standards for medigap products and have long advocated for similar reform of private-long-term care insurance. We are pleased to see the many similarities between the Administration's proposal and the Chairman's Long-Term Care Insurance Improvement and Accountability Act, S. 203, such as mandatory non-forfeiture, simplification, counseling and many other areas.

The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. Without reforms, many of those who are trying to provide for themselves will end up with a false sense of security. While many of the improvements have a cost and may increase initial premium amounts, the protection is more genuine.

Advisory Council. The National Committee is pleased with the Administration's proposal to set up a Federal Advisory Council to develop regulations within three years. Until the these standards are published, the model act standards developed by the National Association of Insurance Commissioner (NAIC) will be used. Despite the good faith effort and hard work by the NAIC, it is appropriate that standards be developed by a national entity. The draft legislation is silent on the composition of the 5-member council except for representation by the NAIC. The National Committee recommends that consumer representation be required on the council—as is required under your bill.

Premium Rate Stabilization. Consumers of long-term care insurance—especially older consumers who are out of the job market—need protection against large and unpredictable premium increases. Caps on premium increases control the risk to the purchaser—which is the primary purpose for buying insurance. Policies should be required to at least contain these three features: a cap on life-time premium increases; limit on frequency and size of periodic premium increases; and no premium increases beyond a certain age. For example, policies could be limited to a life time increase of 100 percent, a maximum increase of 20 percent every few years, and no increase after age 75.

Non-forfeiture. The National Committee supports mandatory non-forfeiture benefits. Protection must be awarded policy holders who have paid premiums for years and, perhaps due to declining health and added medical expenses, no longer can afford the policy—often just when they need it the most. The balance is between meaningful benefits and affordability. Life insurance policies are required to have a non-forfeiture clause. There is no reason why long-term care policies should not have to provide similar protection. We support a non-forfeiture benefit design that would guarantee a shortened benefit period after a minimum number of premium payments. This is preferable to a cash benefit which could induce lapses and is contrary to the purpose of long-term care policies which is to assure services when needed.

Inflation protection. Current generation long-term care policies generally include the option to purchase an inflation protection rider. The National Committee believes it is essential to incorporate in all policies this inflation protection as a standard benefit. If inflation protection continues to be optional, consumers of long-term care policies need to be educated about this potentiality and about the importance of having inflation protection. A nursing home bed that today costs anywhere from \$45 to \$200 a day may double in price in a few years. S. 203 requires a minimum 5 percent inflation adjuster for policies with inflation adjusters. While the predictability of a fixed rate inflation adjuster facilitates the pricing of a policy, this fixed rate could prove to be too much or too little. An alternative would be an Inflation adjuster tied to the consumer price index or a wage index. A wage index might be the best alternative since nursing home costs are closely linked to personnel costs.

Standardized Benefit Products. With federal standards, insurance products are expected to become easier to understand with simple summaries and standardized language. However, the National Committee recommends that a further step be taken. Long-term care insurance products should follow the medigap example and be offered to consumers in standard benefit packages to further simplify policy selection.

Consumer Complaint and Dispute Resolution. The National Committee is pleased to see that under the Administration's proposal states are required to establish administrative procedures to investigate and resolve consumer complaints and disputes between consumers and long-term care insurers. It is important that State Insurance Commissioners can prohibit the sale of policies that fail to comply with applicable requirements. The Federal oversight in the Administration's proposal is also welcomed.

Counseling. The National Committee strongly supports the call for long-term care counseling programs in both S. 203 and the Administration's proposals. Even with simplification of insurance products, education and counseling by knowledgeable individuals will still be needed.

Life Care Act

The Chairman's new legislation to establish a voluntary long-term care insurance program under the Public Health Services Act allows individuals at age 45 and 65 to purchase protection against nursing home costs up to the purchased limits of thirty, sixty or ninety thousand dollars. The asset protection under the Medicaid program would be increased by the corresponding amount.

Mr. Chairman, we applaud your efforts to make available to individuals long-term care insurance that is backed by the Federal government. It would help the middle class person to protect his or her life savings, especially because it is coordinated with Medicaid nursing home benefits. The fact that as a public program there would be no underwriting sets it apart from private insurance. We understand that you have limited the time frames in which individuals can purchase the Insurance to avoid adverse selection. However, It seems unnecessary to restrict the enrollment ages to only 45 and 65.

The Life Care Act would reimburse individuals for care only in nursing homes with an RN on duty around the clock. This is a very welcome improvement on the current RN requirement for Medicaid/Medicare certified nursing homes.

Nursing homes currently are only required to have an RN on duty eight hours a day. In 1988, 73 percent of Medicare/Medicaid nursing homes could not fully meet a similar standard according to a National Committee study. Nursing homes are unlikely to staff up to meet the staffing requirement of the long-term care insurance policy unless this requirement is extended to Medicare/Medicaid certified nursing homes.

Additional requirements for nursing staffing are also needed for direct caregivers and supervisors which are proportional to the number of residents in the facility. For example, there are no staffing requirements for nurse aides, even though nurse aides deliver approximately 80 percent of the care.

Conclusion

The National Committee's 1992 member survey overwhelmingly confirmed the desire for a comprehensive long-term care public program including respite care for exhausted family caregivers. Respondents strongly supported a full nursing home benefit. However, when given the choice between a nursing home benefit or a home care benefit of equal value, respondents choose home care by more than eight to one.

The Administration's proposal for a home and community based long-term care program as a first step follows our member's preferences. Your legislation on voluntary nursing home coverage would appropriately complement the Administration's home and community-based care proposal. Seen together, the two programs

could help ease the fear of becoming disabled and dependent and would hasten the day when this country has a comprehensive long-term care program.

Chairman Kennedy, the National Committee applauds you for your hard work on these critical issues. We look forward to working with you during the next year as these issues are resolved.

Senator WOFFORD. Thank you, on behalf of Senator Kennedy and myself, for your testimony on the bill for a public voluntary insurance program for nursing home care. We commit ourselves to working closely with you to see that we move that along speedily and in parallel and as part of this.

You have answered the beginning of a question that I was going to ask, which is, to what extent do you think senior citizens should be asked to contribute to the cost of long-term care? I wonder if Beatrice Braun wants to comment on that same question, or either of you add more.

Dr. BRAUN. AARP has all along said that they felt that long-term care should be a social insurance program and that everyone should contribute so that anyone would be able to use it at any time. I think we still feel that way, and of course, in our Health Care America, we had an income tax which would be dedicated—that was to the entire health care program. But in our surveys, we have found that many people would be willing to pay a tax that was dedicated to long-term care, and that would perhaps be an equitable way of financing it.

It does need to go across not only the seniors but, as we heard this morning, one-third of the people who would use it are not seniors. So it needs to go across the entire population to provide long-term care. But the seniors are certainly willing to do their part.

Senator WOFFORD. It should not be limited to age, and if we did not know, we have learned this morning.

Mr. RICHTMAN. Senator Wofford, I just might add that our members also feel that they should pay their fair share for this very important benefit, and I think some of the comments just made by AARP make a lot of sense on our behalf as well.

Senator WOFFORD. Would you prefer a Federal program like Medicare in this field over a State-administered program?

Mr. RICHTMAN. What we are concerned about is—it is a fine line—we recognize the need for State flexibility; at the same time, we need some very strong Federal guidelines to make sure that, for example, all States do offer this program. Under the administration's proposal, it is theoretically possible that a State might choose not to have a long-term program; perhaps they would not have the resource to provide the match. And that is something that we are very concerned about.

The CHAIRMAN. Tony Young, Senator Harkin would like me to ask this question, and it is in line with one I wanted to ask you, so if I may put his question to you. He notes that in your written testimony you talked—as you did today—about consumer direction and consumer control with regard to personal assistance services. The President's bill would require States to ensure quality in part by measuring the extent of participant satisfaction with services received. Would you elaborate on why consumer direction and consumer-oriented quality assurance are important and how, if at all, the administration bill could be improved in these areas?

Mr. YOUNG. Well, consumer direction of personal assistance services really falls to the core of what personal assistance is all about. We all have our own life goals. Some of us want to get more education, some of us want to work, some of us want to be involved in the community. We cannot do that because we do not have the support services now to get out and get involved.

What we have is a situation where often, services, if they are delivered, come at any time during the day, delivered by people whom you do not know or you are not familiar with, who may or may not know what you need. What we need is a system where people with disabilities, of any age, can define what they need, the services they need, what they want to do with their lives, and then join those needs and services together in order to be able to achieve their own self-directed goals.

The only way you can really find out if that is working is if the services are evaluated on the basis of the outcomes that people choose for themselves. And putting the person with the disability in charge of his own services means that then he can find them, he can schedule them, he can empower himself through these services in order to go out and be a participating and contributing member of society.

In terms of improving the President's proposal, I would frankly like to see the advisory committees turned into controlling committees that design the service systems and then submit them up the line, instead of simply being able to comment on what is happening. I would like to see a little more control by consumers of all ages put into those committees.

Senator WOFFORD. Thank you.

Paul McCarty, would you tell us a little more about the single point of entry for long-term care services in Massachusetts and whether this is a model for the new Federal program?

Mr. MCCARTY. Certainly. Actually, in 1974, I worked at the State Department of Elder Affairs, helping to design it. It is a comprehensive care planning, single-entry-point system that in fact in the past 5 years has tied together not only the State home care dollars, which are non-Federal dollars, but also Medicaid dollars have now been tied together for screening and care planning purposes.

The system works very simply and very well with a single entry point care planner. I would make two personal observations on the Massachusetts model. First of all, we do not pay the care planners anywhere near adequately under our system. They are not at a professional level that I think this plan would call for. Entry salary is \$16,000 a year for care planners, who are making decisions about 100 clients in their care load that are at least \$2,500 worth of service per client. We need to have a more professional level of care planners out there. That was mentioned earlier, and I think it was appropriate to take a look at what the geriatric assessment mechanism is, who is driving that. From an Alzheimer's Association point of view, I have said for the 10 years I have been involved with the Association that it is easier to put a care plan together for frail knees than for frail minds. And it is true, in my experience as a provider of Alzheimer day care services and in-home care services, helping care planners to recognize the cognitive losses and dif-

difficulties and the family need for support and respite is very difficult and very complicated.

Senator WOFFORD. I want to thank all four of you very much. In fairness to our next panel and to our need to hear from them, I have to excuse you now, unless Senator Kassebaum has questions or comments.

Senator KASSEBAUM. Mr. Chairman, I apologize for coming in late. I would just like to comment on Mr. McCarty's remark about the caregivers in long-term care, who really have not received the commensurate salaries for the important care they give. And this is an important component, I think, of addressing the whole question of how we do this.

I would just like to say I certainly think that is a good point.

Mr. MCCARTY. We agree.

Senator WOFFORD. As I turn over the chair, I apologize to the next panel that I have an obligation that I have to meet, too, but I will read your testimony with great interest, and I am turning the chair over to Senator Kassebaum, who is deeply committed to the proposition that long-term care is a problem we must solve and deal with together and do it to the best of our ability on this occasion with this legislation.

Thank you.

Senator KASSEBAUM [presiding]. Is Susan Van Gelder here?

[No response.]

Senator KASSEBAUM. Is anybody here representing the Health Insurance Association of America?

[No response.]

Senator KASSEBAUM. I would like to welcome the fourth panel. We very much appreciate your patience and perseverance in waiting until last, but I think that you offer important testimony.

If I may just make a comment, I have been trying to split time between a couple of other committees this morning. I strongly support long-term care coverage—I am sure there has been a great deal of moving testimony this morning—it is a benefit that I believe is important to include in a health care reform package. That does not mean there are not enormous difficulties about how to include it and the cost of doing so. But I think that just to say we cannot deal with it does not help us solve the problem. So I appreciate those of you who are here, and is this panel, addressing these issues.

First, Mr. Val Halamandaris, president of the National Association for Home Care, and then, Dr. Paul Willging, executive vice president of American Health Care Association. I appreciate very much both of you being here.

Mr. Halamandaris.

STATEMENTS OF VAL HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, DC; PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC; AND SUSAN VAN GELDER, DEPUTY DIRECTOR OF POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. HALAMANDARIS. Thank you, Senator, and with your permission I would like to enter my statement in the record and just summarize very briefly.

Senator KASSEBAUM. Thank you.

Mr. HALAMANDARIS. I have spent all of my adult life working on this one issue as counsel to the Senate Aging Committee and then later for Claude Pepper on the House Aging Committee. I am absolutely delighted that the President has shown the initiative and has included long-term care in the President's package.

I spent most of the summer in a bus, traveling the country, all 50 States, some 16,000 miles, asking the American public what they wanted. I wanted to test my prejudices and find out if I was reflecting accurately what the American people wanted. And through that tour, which was called "Health Ride," in the "Speak Out, America" campaign, we learned that the American public wants most of all help with long-term care. It was a much more important problem than access, because the access problem that affects 30 million or maybe more American people eventually is addressed; if your income and assets get down to a certain level, you are eligible for Medicaid. Whereas the problem of long-term care is completely unsolvable. There is nothing you can do to protect yourself. You cannot save enough money, and you cannot buy enough insurance to protect yourself against that eventually.

I heard Senator Rockefeller talk to our association about Alzheimer's affecting his mother. He told that group that, "Our family has resources. Everybody knows we have resources. But it taxed those resources to the limit to care for our mother who had Alzheimer's. I simply pity those people who do not have resources."

This is a national problem that must be addressed. We commend the President and those of you in the Congress and the Senate who have worked so hard to elevate the issue to the public consciousness. I am delighted to see that it will be addressed this year.

There are some significant problems with the legislation, obviously. One of the problems relates to the funding of it, which we think is very shaky. I wrote a letter to the President, commenting about the \$124 billion proposed in Medicaid/Medicare cuts. What I told the President at that time was that, "It is impossible, Mr. President, to make a new covenant with the American people by breaching an existing covenant. You have to honor the commitments you make to the American public. This Congress has made a commitment to the senior citizens of our Nation in the form of Medicare. We cannot break that covenant. One hundred twenty-four billion dollars is simply too much to be cut. It cannot be cut effectively without jeopardizing that program."

If you look at it very cynically, if that cut is sustained, the senior citizens will lose \$124 billion, and they stand to gain some \$70 billion in a new drug benefit, and if you allocate to them half of the

long-term care benefit when fully funded, that \$34 billion a year in the year 2003, the effect is that the elderly of this country would gain approximately \$90 billion and lose \$124 billion, which is a net loss of some \$34 billion.

So let us not pretend that we are doing something when we are doing something else. There is enough cynicism in America today. We need to be forthright with the American public and tell everyone what we are going to do.

And wrapping up, I would like to talk about values. President Kennedy years ago suffered two defeats in trying to get Medicare through. Then he made a famous speech on the floor of the House of Representatives in which he quoted the historian Arnold Toynbee. He said Toynbee had done a study and indicated that you could tell the greatness and the durability of all civilizations by a common yardstick, and that yardstick was the manner in which they took care of individuals that are on the fringes of life—the handicapped and the disabled. What the President said, therefore, is that Medicare and the issue involved really was an issue that related to the very survival of our Nation, and not only that, but also how we would be judged through the prism of history.

I put it that President Kennedy had it right, and when he began to talk about values, the Medicare program began to pick up momentum. The question, then as now, is not whether we can afford it; it is whether we can afford not to do it.

I would just summarize and say that there can be no health care reform which does not address this problem of long-term care. It is absolutely crucial. I sat through several instances where the Congress flinched and did not face up to that responsibility, specifically, in the Medicare program, which I helped write, and particularly the home care provisions thereof. Years later, when we questioned the giants, Wilbur Mills, Wilbur Cohen, Claude Pepper and others who helped create the Medicare program, and asked what we did right and what we did wrong, what they uniformly said we did wrong was that we failed to cover long-term care, that we put too much emphasis on the acute care side, and therefore we were spending dollars unnecessarily by waiting until people were so ill that they had to go into the hospital emergency room.

So my plea to you is to make sure at all costs that this time, we do address the problem; that is absolutely crucial, and I believe we will.

Thank you very much.

Senator KASSEBAUM. Thank you very much.

[The prepared statement of Mr. Halamandaris follows:]

PREPARED STATEMENT OF VAL J. HALAMANDARIS

My name is Val Halamandaris. I am President of the National Association for Home Care (NAHC), which represents the nation's home care providers—including home health agencies, home care aide organizations, and hospices—and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC has long advocated the development of a national plan to ensure universal access to basic acute care and long-term care services.

NAHC believes that no health care proposal is complete without ensuring access to high quality home care and hospice in both the acute and long-term care setting. These vital services provide millions of individuals—the aged, infirm, disabled, and

children—the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity—in their homes.

REFORM PLANS MUST ADDRESS NEED FOR LONG-TERM CARE

Any action taken on health care reform must not overlook the growing need in the U.S. for a comprehensive long-term care program. It is impossible to separate the need for reform of the current health care system from addressing the need to include a long-term care component.

Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million. The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthweight children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Spending for long-term care is currently estimated at \$57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-term care. Many families exhaust their emotional and financial resources providing and purchasing long-term care. A million Americans a year go bankrupt trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care services can also be cost-effective. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of \$1,100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs \$1,000 a month for home care compared to \$2,100 a month for skilled nursing facility care, according to the program director. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.

The National Governors' Association (NGA) has recognized the importance of home care services and in a resolution adopted in 1992 stressed the importance of making home- and community-based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost-effective method of care.

PRESIDENT'S PLAN WOULD ESTABLISH HOME-BASED LONG-TERM CARE PROGRAM

The President's health care reform proposal would establish new federal programs for long-term home care services that would be run by the states and provide additional expansions and improvements in Medicaid long-term care programs. The significance of these provisions cannot be overemphasized. Millions of Americans now go without needed long-term care or are forced to impoverish themselves to qualify for minimal Medicaid coverage.

The President's plan also contains two important provisions that the National Association for Home Care has strongly supported over the years. First, the plan would permit disabled Americans who are under age 65 to qualify for these desperately needed home- and community-based services on the same basis as the elderly. Second, the plan would not require states to use costly external case management procedures that duplicate standard caregiver activities. Third, access to benefits would not be based on income. However, the plan would apply a copayment schedule based on clients' income levels.

The federal government would provide most of the funding for the new long-term home care program and establish minimum eligibility and benefits guidelines. States would administer the program and contribute an amount of funding roughly equal to their current spending on long-term care for the severely disabled. Federal spending on this new program is expected to total \$57 billion in the first five years and \$38.3 billion a year when fully implemented in the year 2003. To qualify for benefits under the new program, an individual would have to need assistance in performing at least three of five specified activities of daily living (bathing, dressing, transferring, toileting, eating). Individuals who have severe cognitive or mental impairment, or individuals who have severe or profound mental retardation could also qualify. In addition, individuals under the age of six who are dependent on technology and who would otherwise require hospital or institutional care would be eligible for services.

At a minimum, states would be required to include coverage for personal services for assistance with activities of daily living. States would have the flexibility to provide other home- and community-based services such as homemaker and chore assistance, respite services, and adult day care services.

State Medicaid programs would back up these programs for the severely disabled by providing home- and community-based services for low income individuals with fewer than three ADL deficiencies. Medicaid would also continue coverage for low income individuals who need nursing home care. Enhancements to the Medicaid long-term care program would include: (1) an increase in the personal needs allowance from \$30 to \$70 a month; (2) an increase in the level of protected assets from \$2,000 to as much as \$12,000, at the option of the state; and (3) states must set financial eligibility at a point that is no lower than 551 eligibility.

The proposal would establish federal standards and tax preferences for private long-term care insurance policies. The federal standards would not require minimum benefit packages but would require private long-term care insurance plans to: base eligibility for services on functional ability; provide nonforfeiture features (e.g., require a portion of premiums to be refunded when policies terminate); provide inflation protection, and meet additional consumer protection standards. Plans that meet these standards would qualify for tax deductions for policy premiums paid by individuals and employers.

Additional tax incentives would be established to support certain disabled individuals who work. For example, employed individuals who require assistance with activities of daily living and who purchase personal care and personal assistance services could obtain tax credits for up to 50 percent of their costs, up to a maximum of \$15,000 per year.

NAHC COMMENTS ON PRESIDENT'S LONG-TERM HOME CARE PROGRAM

The National Association for Home Care applauds the President's commitment to providing needed long-term care to the millions of Americans with chronic disabilities. This crucial component of the Health Security Act will help make the promise of health care for all a reality for the young, the elderly, and all disabled Americans.

We especially applaud the President's reliance on home care as the foundation for this new federal long-term care program. Home care has a long and distinguished history of caring for individuals of all ages in the setting they like best—in their own homes where they can maintain their dignity, their independence, and their individuality.

NAHC has several concerns regarding the President's plan that we think should be carefully considered. First, of primary importance is that the program should be adequately and realistically funded. The promise of long-term home care will not become a reality until real funding sources are proposed to meet the needs. The President's proposal uses massive new Medicare cuts, along with an excise tax on cigarettes for the long-term care program.

NAHC is opposed to the proposed cuts in the Medicare home care benefit contained in the \$124 billion in proposed Medicare cuts. Home health care has already been hit hard by administrative cutbacks in the Medicare cost limits and this year's reconciliation bill, and the proposed new cuts could seriously jeopardize patient access to care. We hope Congress will choose not to enact such deep and imposing cuts in the Medicare program. In addition, cost estimates show that revenues from the cigarette excise tax are expected to diminish over time.

Both the near-term and long-term revenues for the long-term home care program are somewhat in doubt. NAHC strongly believes that funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.

A second concern is that the Administration's proposal may not meet the needs of all Americans in need of long-term care. Primarily due to financing pressures, the Administration has chosen to limit the program to individuals with limitations in three or more activities of daily living (ADLs). This is indeed a very needy population, but it leaves on the sidelines a large and growing number with limitations in two or fewer ADLs who are equally in need of care. It is important to note that an individual unable to carry out even one ADL can be extremely disabled and in need of long-term care. For example, an elderly individual, living alone with no family or other caregiver close by, who needs assistance with only one ADL, such as eating, would benefit greatly from a relatively small amount of long-term home care.

We understand the need to begin new programs conservatively, but we hope that the Administration will work to provide long-term care to all those in need within a reasonable timeframe.

A third issue of concern to home care providers is that of case management. The President's long-term proposal would allow all qualified entities, including home care agencies, to perform case management functions. We support this permissive language that would enable each state to choose case managers for their programs. Many home care agencies perform these important functions today and resist the notion that only a separate additional agency can correctly perform important case management functions. Outside case management, in many cases, does little more than increase administrative costs and layers of bureaucracy that are placed between patients and providers.

Finally, NAHC is concerned that health care reform plans use adequate quality assurance mechanisms. The use of outcome-based mechanisms is at this time little more than a theoretical possibility. Until such mechanisms are available, NAHC recommends the requirement of standards for organizations delivering in-home skilled services can be found in the Medicare Conditions of Participation for home care and hospice. For nonskilled service providers, suitable standards can be based on the requirements developed by the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the National HomeCaring Council, which have developed special standards for training, testing and supervision of paraprofessional workers employed by home care aid organizations. These provider standards serve as important protections for consumers.

The President's plan also allows eligible individuals to independently contract and supervise home care aides. While there are a limited number of cases where this may be appropriate, the vast majority of individuals eligible for services under the long-term home care program should receive services from qualified home care agencies. In cases where independent providers are used, the legislation should ensure that they are appropriately trained, tested, and supervised as well as provided with basic employee benefits—including health care coverage—and other support.

SUMMARY

Inadequate access to acute health care and long-term care is the single most devastating problem facing America. And this problem will only get worse unless prompt action is taken. Reform legislation must address the need for access to both basic health care coverage, including home care and hospice services, and a comprehensive array of long-term care services based on home care.

Without federal reform, health care costs will continue to increase while access to basic services and long-term care services deteriorates. Congress should make the most of the current climate of support for change and make health care reform a top priority for action next year.

The President's proposal represents a paradigm shift toward federal coverage for care in the home setting. We are excited and optimistic about the potential for this landmark change. The National Association for Home Care looks forward to working with the Administration and Congress toward enactment of a health care reform plan that will contain the increases in health care costs while achieving universal access to high quality care.

Senator KASSEBAUM. Mr. Willging.

Mr. WILLGING. Thank you, Senator Kassebaum.

I am Paul Willging, executive vice president of the American Health Care Association, which represents the vast majority of all nursing and allied health facilities in this country, some 11,000 separate entities.

I too wish to laud this committee for its obvious interest in the area of long-term care over the course of the course of the past

years, certainly reflected in Senate bill 203, the proposal for the Long-Term Care Insurance Improvement and Accountability Act. Equally important, I think, is Senate bill 1600, the Secure Choice Act. They are proof that this committee have recognized that long-term care is a critical part of health care delivery in this country.

I think one must also applaud the President not just for having initiated this debate on overarching comprehensive health care reform, but for also having recognized that you cannot, as Mr. Val Halamandaris has said, deal with health care without recognizing long-term care as well.

And many of the provisions in the Health Security Act certainly need to be supported. We may quibble on some of the details. Even in terms of the home and community-based care program, while I am not sure one does not eventually have to look at the concept of means-testing, it still recognizes the long-term care consists of a continuum. It is not just nursing homes. And indeed, there has perhaps been an institutional bias in the Medicaid program over the years. One has to look with equal favor on home care, foster care, congregate living, personal assistance. All of these are a critical part of the continuum.

I think, however, that the Health Security Act and its long-term care provisions has also recognized that in fact the largest financial catastrophe that faces America's elderly in the area of long-term care does relate to nursing home care, and that by requiring States to put in place a so-called "spend-down program" for nursing home care—that is, that Americans can utilize their health care bills as they try to establish eligibility for Medicaid—is a critical component of that program—and also to try to make the existing Medicaid program more humane by increasing the personal needs allowance from \$35 to \$70, by allowing States the option to increase the retained asset level from \$2,000 to \$12,000. And I do not think we should forget what members of this committee have already done, particularly my Senator, Barbara Mikulski, and the spousal impoverishment provisions last year. Through those kinds of activities, we are talking about a more humane program.

Also, the recognition in the President's proposal that hospitals are not always the preferred location for health care services and his recognition in the Act that in many cases, home care agencies, nursing facilities, hospices, can provide equally qualified care at much less cost. That certainly is going to be one mechanism of getting a handle on this cost problem we are dealing with.

I think most critical, however, Madam Chairwoman, is in fact the reference in the President's proposal regarding long-term care insurance. I think it is a recognition that this problem is too monumental for the Federal Government or even public funding, Federal and State, to be the total solution.

I think we have already seen what happens when we rely excessively on public funding for an issue as critical as long-term care financing. Look just at the Medicaid program today. Sixty billion dollars of national resources flow into my industry, the nursing facility industry. Sixty billion. Forty-eight percent of that is picked up by the Medicaid program. We are talking about \$30 billion public funding for nursing home care. That program, nursing facility care, is growing, however, at a rate of 13 percent per year. We are

talking about a program, total funding, public and private, which will double every 5 to 6 years. We are talking about a program which, within 10 years, will cost \$200 billion. Worse, 10 years from now, 20 years from now, 25 years from now, it will not be 48 percent of that figure picked up by Medicaid; it will be 67 percent.

I do not think there is anyone in this room who feels sanguine about the concept, the prospect, the likelihood that public funding can pick up 67 percent, or worse, 100 percent, of a \$200 billion and then a \$300 billion and then a \$400 billion program. We clearly need to marshal the resources of the private sector. And I think the President's recognition of long-term care insurance as a critical component of that is to be applauded.

How do we do it? I think we do it with many of the provisions in the President's bill. We have to instill the concept of value in the minds of the consumer. If they do not see long-term care insurance as a valuable good or service, they will not purchase it.

How do we do that? One, we educate. It is amazing to know that still, 50 percent of all Americans think that if they do in fact need long-term care services, an extended stay in a nursing home, it will be picked up by Medicare.

Now, how can they see value in long-term care insurance if they think they are already covered? It just will not work. Education is important. Tax clarifications are important so that people understand for the first time whether the premiums and the benefits are going to be treated one way or another.

And I think consumer protection is critical. With one or two exceptions, I think many of the provisions in Senate bill 203, the Long-Term Care Insurance Improvement and Accountability Act, make a lot of sense to instill the concept of value.

I think on this particular point, however, one has to be careful. You can protect so much that you in fact price the product out of the reach of the consumer. A good example is perhaps the so-called nonforfeiture provisions of that bill, which would suggest that if you in fact for an extended period of time have paid premiums, but you allow your policy to lapse, you will get a benefit back.

I kind of look at that in a way analogous to term life insurance versus whole life insurance. If I want to buy term life insurance, I should be allowed to buy term life insurance. I should not, under the guise of consumer protection, be told that I really have to buy whole life insurance, that I will get something back on the premiums. I do not consider myself protected by being told I have to buy a benefit that I do not want. I think I should be offered the benefit; I do not think I should be forced to purchase that benefit.

But in conclusion, Madam Chairwoman, I think what we are arguing for is in fact this attention to the issue of long-term care—it is critical; one cannot deal with health care without dealing with long-term care—but to do it within the context of a public-private partnership. Government funding must be preserved, has to be preserved to deal with those truly in need. The private sector should marshal its own resources, with the stimulation of Government, so as to do what it is capable of doing. In that regard, I would love to work with this committee and with you over the next year as we try to structure this kind of a program.

Thank you very much.

[The prepared statement of Mr. Willging follows:]

PREPARED STATEMENT OF PAUL WILLGING

Mr. Chairman, members of the committee, I am Paul Willging, executive vice president of the American Health Care Association (AHCA). The more than 11,000 long term care facilities that make up our Association care for more than one million elderly, frail, and/or disabled residents. We commend you, Mr. Chairman, for holding this hearing and for your leadership on long term care care—one of the most critical areas of the health care debate. On behalf of AHCA's members, and the residents of nursing facilities, thank you for the opportunity to speak at this important hearing.

The American Health Care Association applauds the President and First Lady for offering comprehensive health care reform legislation—comprehensive in that it begins to address the need for long term care financing reforms. Likewise, AHCA commends your work to move from these proposals to practical programs. I hope that AHCA can contribute to the successful outcome of that work.

The Clintons' legislative proposal, the "Health Security Act," includes a number of significant long term care provisions. AHCA wholeheartedly supports some of these provisions. Others concern us. Today, I will do my best to share both AHCA's praise and doubts concerning the various long term care provisions of this important proposal. My testimony will emphasize our beliefs that: the private sector must play a significant role in supporting long term care; private long term care insurance can be the cornerstone of strong private/public partnership; and there are things that the federal government must do—and must not do—to support a long term care private/public partnership.

THE NEED FOR CHANGE IN LONG TERM CARE FINANCING

Our society, individually and collectively, has not made adequate provision for financing the costs of long term care. Individuals and families are not saving for, or insuring themselves against, the costs of long term care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

Without action to address these problems, our growing elderly population will come to rely much more heavily on Medicaid to pay for long term care. Currently, Medicaid accounts for approximately 48 percent of all long term care payment and about 67 percent of all nursing facility residents in the United States. If current trends continue unchecked, Medicaid will be burdened with an ever increasing share of the nation's long term care costs as the baby boomers reach retirement. But these current trends cannot continue. Federal and state budgets—already strained badly by current Medicaid long term care obligations—cannot bear such costs. Nor would the elderly be well served by an overwhelmed publicly financed program.

Recent (February 1993) Gallup Organization survey results indicate that 76 percent of Americans agree that "government should pay the cost of nursing home care only for those who cannot afford it." In order to meet the nation's growing long term care needs without both emptying the public purse and sacrificing quality of care, our society cannot afford to rely solely on government. Instead we must encourage and enforce an expectation of personal responsibility on the part of those with the means to plan for and pay for potential long term care costs. Government can—and must—help in this effort by working to see that individuals have the information and resources to accept responsibility for meeting their own long term care needs.

Long term care costs are impoverishing senior citizens

Most elderly Americans are unaware of the magnitude of long term care costs and of the limits of government assistance. Most Americans do not foresee needing long term care. Most probably do not realize how costly months or years of long term care can be. Many Americans wrongly assume that government programs or their general health insurance will cover the costs of any long term care services they might need. For all these reasons, individuals and families face long term care costs for which they have not planned and which they cannot afford.

The cost of long term care can quickly wipe out the assets of those who have worked and saved for a lifetime. The cost of one year of nursing home care is more than triple the average annual income for an elderly American. But the nation's current long term care policy does not promote personal planning, saving, or the purchase of insurance against the financial risk of long term care costs. Nor does our nation provide comprehensive social insurance against the financial catastrophe of long term care costs. Only after a long term care recipient has been impoverished

does government assistance become available through Medicaid—a “welfare” program.

Medicaid is impoverishing the Federal and State governments

According to the health Care Financing Administration (HCFA), total Medicaid spending (state and federal) has doubled over recent years—from \$48.2 billion in FY 1987 to \$96.4 billion in fiscal year 1991. HCFA expects Medicaid to cost \$141 billion in FY 1993. If current trends hold, HCFA projects that total Medicaid spending could rise to \$230 billion in FY 1997.

The controversy in California over the cost of nursing home reform, the countless court battles over Medicaid reimbursement, and the protracted battle over “provider specific taxes” well illustrate the strain that Medicaid is putting on state and federal resources. This strain jeopardizes the accessibility and quality of both acute and long term care for those who must depend on Medicaid. Clearly, if current long term care needs have stretched federal and state budgets to their limits, future needs will overwhelm our current arrangements for long term care financing. Therefore, the nation must look to other sources than government for additional resources to meet the future long term care needs of an aging population.

We believe that long term care reform should have the following goals: providing appropriate access to the full continuum of long term care services; ensuring that all Americans have the means to meet the cost of long term care; moving individuals and families away from dependence on government welfare programs for long term care financing; and addressing the nation’s long term care needs in a fiscally responsible way.

The role of private long term care insurance

Results from a March 1993 Gallup Organization survey indicate that 79 percent of Americans agree that “to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans.”

Private insurance, so useful in protecting individuals and families from such costly misfortunes as accidents and illness, has great potential for marshalling private sector resources to meet long term care costs. Insurance offers a very good means to preserve an individual’s choice from among various long term care arrangements and competing providers. Its expanded use would make an appropriate private/public long term care partnership viable. It has great potential for lessening the long term care cost burden that the graying of America will otherwise put on the American taxpayer.

To date, private insurance accounts for less than two percent of all payments for long term care services. AHCA is confident, however, that with appropriate changes in federal policies private long term care insurance can and will take on a larger role in meeting long term care costs. In order to expand the role of private insurance, a number of things must change. Chiefly, long term care insurance policies must have value to consumers. In order to enhance the value of long term care insurance to consumers, Congress and the Administration must: establish federal standards and consumer protections; clarify the federal tax treatment of long term care insurance; educate Americans about the risk of, cost of, and means of financing long term care; and allow states to try innovative private/public partnerships between private long term care insurance and Medicaid.

This Congress has already taken another key step toward realizing the potential of private long term care insurance. OBRA ’93 closed loopholes in the current Medicaid program that permit affluent elderly to claim benefits meant for the indigent. These provisions are crucial to maintaining the appropriate balance between public programs and private resources in financing long term care.

Federal standards and consumer protections

First, thank you, Mr. Chairman, and Members of the Committee, for your leadership on efforts to establish federal standards and consumer protections for long term care insurance. The Long-Term Care Insurance Improvement & Accountability Act (S. 203), sponsored by the Chairman and cosponsored by Senators Hatch, Durenberger, Metzenbaum, Simon, Bingaman, Wellstone, and Wofford, has a great deal in common with our own proposals.

Appropriate federal standards and consumer protections for long term care insurance would inspire consumer confidence; foster the growth of the private long term care insurance market; and ensure that elderly consumers are spared the problems that once plagued the “Medigap” insurance business. As long term care providers, AHCA’s members do not benefit from private insurance policies that provide inadequate coverage. Providers do not benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Ac-

cordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, AHCA recommends that proposed federal standards be balanced by considerations of affordability. Congress needs to consider carefully the trade-off between the value of a policy feature and the cost to consumers of mandating that feature.

Clarification of the tax status of long term care insurance

AHCA supports treating long term care insurance contracts in the same manner as accident or health insurance contracts. Specifically, AHCA supports the following clarifications to the tax treatment of long term care insurance:

- treatment of long term care insurance premiums paid by individuals in the same manner as accident and health insurance premiums;

- treatment of benefits received under long term care insurance contracts for long term care services in the same manner as benefits received under accident and health insurance;

- treatment of employer plans providing long term care services in the same manner as accident or health plans;

- treatment of life insurance benefits paid to a terminally ill individual in the same manner as death benefits;

- inclusion of long term care options as preferred employee benefits in employer programs, including cafeteria plans; and

- clarification of the allowance of tax deductions for additions to an insurer's long term care insurance reserves.

LONG TERM CARE PROVISIONS OF THE HEALTH SECURITY ACT

The long term care provisions of the Clinton Administration's proposed Health Security Act call for: the expansion of home- and community-based long term care services; changes in Medicaid eligibility for long term care coverage; the establishment of federal standards and tax incentives for long term care insurance; and a demonstration program of models for the integration of acute care and long term care.

In general, AHCA supports the thrust of each of these facets of the Health Security Act. Our members favor enhanced access to home- and community-based long term care—but that access must be geared toward the appropriate population with the appropriate consideration for cost-effective placement. AHCA also supports measures to end the impoverishment of long term care recipients. Perhaps most relevant to this hearing, AHCA strongly supports federal standards and consumer protections for private long term care insurance—provided that those federal standards do not raise the cost of long term care policies out of the reach of those who otherwise would benefit from coverage.

In particular, I would like to raise a number of concerns regarding the specifics of the long term care provisions of the Health Security Act.

Expansion of home- and community-based long term care

The Health Security Act would create a new program for home- and community-based long term care. The proposed program would provide a broad array of long term care services—regardless of age or income—to a broadly defined disabled population. The federal government would provide most of the funding under a federal/state partnership. The program would cap funding based on the estimated cost of serving the disabled population. Eligibility for program benefits would be based on need for assistance with at least three out of five activities of daily living (ADLs), cognitive impairment, profound mental retardation, or—for children under the age of six—dependence on technology and risk of institutionalization.

AHCA's concerns with these proposals are that they probably are too good to be true. We have serious doubts that the federal and state governments can provide the contemplated long term care services to this broad a disabled population at the currently estimated costs. This skepticism leads us to wonder what the consequences would be for those would-be beneficiaries who expect more than the program can afford, for taxpayers, and for long term care providers. How would states hold program expenditures to their capped allotments? What would happen to disabled individuals who meet the program's functional criteria and expect long term care services that a state cannot afford to render?

Believing as we do in the need for a strong private/public partnership in long term care, the President's proposal for an ambitious new government program presents

other concerns. Having heard of the President's plans for a new program for long term care, our members are concerned that most Americans will believe there is no longer any need for them to plan for, save for, or insure against the costs of long term care. If this sounds pessimistic, consider that after more than 25 years of Medicare, a public opinion survey conducted for the Employee Benefit Research Institute by the Gallup Organization this summer found that 45 percent of respondents believe that Medicare pays for long term care.

The proposed new program for home- and community-based long term care raises a few other concerns with regard to coordination with other sources of long term care financing—both public and private. First, states might find the coordination of disjointed long term care programs to be awkward and cumbersome. While the remaining Medicaid long term care program could require one kind of eligibility determination for the elderly and the impoverished, the new home- and community-based program would require a different eligibility determination. Second, because of the proportionately larger federal match for the new home- and community-based program, states might be tempted to de-institutionalize Medicaid beneficiaries—even beneficiaries who would not be well or cost-effectively served in a home or community setting. Third, to the extent that a the program leaves doubt as to who or what a state will be able to cover in a given year, the new program could be difficult to coordinate with private long term care insurance. Finally, and perhaps most importantly, we are concerned at the lack of quality assurance and oversight for the proposed home- and community-based long term care program. We would urge the Congress to safeguard the beneficiaries of the proposed program with federal and state oversight which parallels that in force for nursing facility long term care.

In sum, regarding the President's proposals for a new program for home- and community-based long term care services, AHCA favors an approach that makes the entire long term care continuum stronger and more accessible. The nation's frail elderly will continue to need access to nursing facility services, as well as home- and community-based care. Although appropriate for many, home- and community-based long term care is not appropriate for many other disabled individuals for whom nursing facility care is both necessary and cost-effective. For the more severely disabled, for those who have the need for extensive skilled nursing care, and for those who have no family or social support, nursing facility care is the only way to ensure their well-being. Therefore, the Administration and Congress must not strengthen one part of the long term care continuum to the detriment of another.

Federal standards and tax incentives for long term care insurance

AHCA is especially pleased that the Health Security Act includes provisions to establish minimum federal standards for long term care insurance and to clarify the federal tax treatment of private long term care insurance. Both steps will help establish the value of long term care insurance in the eyes of consumers and help private insurance realize its potential in financing long term care.

Of some concern, however, is the Health Security Act's proposed requirement that all policies provide for non forfeiture of benefits in the event of a policy lapse. Because of the cost that this feature adds, and our preference for flexibility and consumer choice, our Association would prefer that nonforfeiture be offered as a policy option. Nonforfeiture is a policy feature that can be expected to benefit only a small proportion of long term care insurance purchasers. Yet it raises premiums on the order of 40 percent. Nonforfeiture, therefore, might not be valuable for most potential purchasers. However, if non forfeiture is to be a required feature of all private long term care insurance policies, the benefit must be designed in a way that maintains policy affordability. We hope that AHCA can help the Labor and Human Resources Committee in this regard.

THE LIFE CARE ACT

AHCA is concerned, Mr. Chairman, by the proposed legislation, the Life Care Act" which we understand you plan to introduce soon. We are concerned, not because we disagree with you about the need for greater insurance coverage for nursing facility care. Rather, we believe that nursing home insurance is something the private sector can and should provide.

The private long term care insurance market is growing and improving. Products have evolved and improved. Insurance companies have gained experience and expertise in designing and pricing policies. Sales have been rising by 30-35 percent a year over recent years. There have been some two million long term care policies purchased. We believe that the private long term care insurance market is on the way to realizing its potential. With the right kind of federal standards, consumer protections, tax clarifications, and public education, consumers will come to understand

the value of long term care insurance. Private insurance can then become a full partner in a private/public long term care partnership.

Since we believe that private long term care insurance is viable, we see no need for a parallel federal nursing home insurance program. Rather than put the federal government in competition with private long term care insurers, we much prefer the approach that Members of this Committee have taken in the Long-Term Care Insurance Improvement & Accountability Act. Not only is there no need to duplicate the efforts of appropriately regulated private long term care insurers, doing so would cripple the private insurance market. Hence, congressional concerns regarding the viability of private long term care insurance would become a self-fulfilling prophecy.

If the Life Care Act were to become law, along with the Health Security Act, Americans would face a very disjointed and confusing long term care financing system. An individual who wanted to plan ahead might expect coverage for home- and community-based long term care from the President's proposed program. But since he or she would find it very difficult to know how fiscal circumstances might affect that program's future coverage and services, it would be difficult to know the value of private home and community long term care insurance. Also, he or she might strongly prefer home and community long term care to nursing facility care, but could have no idea in advance which might be appropriate. The Life Care Act, which would sever coverage for home and community care from nursing facility care, would make planning for long term care more bewildering than it already is. We suspect that de-coupling coverage for the different parts of the long term care continuum in this way would not only confuse consumers, it might also make it much more difficult to sell coverage for nursing home care. Most importantly, consumers who guessed wrong would suffer unnecessarily.

AHCA feels strongly that the federal government should focus its resources and efforts on those who do not have the means to save for, or insure against, the costs of long term care. Where market mechanisms exist to meet a need or solve a problem, there should be a presumption against resigning the need or problem to government responsibility. This nation has a long history that well demonstrates the fiscal and political consequences of too readily ceding problems to government solutions. If, given a real chance—through the adoption of policies outlined in this testimony—market mechanisms fail to meet the need for long term care financing, then it might well be appropriate to resort to a government program. I would add that, if the market fails to address a need, the nation can always try a government-based alternative. However, if a government program fails to address a need, it is all but impossible to return to a market-based solution. If government fails, there is only more government.

There is, however, a facet of the Life Care Act that we find especially attractive. The proposed program would encourage the purchase of insurance by offering Medicaid spend-down protection equivalent to the amount of coverage purchased. This is an idea already being put into practice, largely through the work of the Robert Wood Johnson Foundation, in Connecticut, Indiana, New York, California, and Iowa. Unfortunately, OBRA '93 included a provision expressly intended to discourage other states from establishing this kind of partnership between long term care insurance and Medicaid. We agree with the Chairman that offering enhanced Medicaid asset protection in return for the purchase of long term care insurance is an excellent idea. We think states ought to be able to pursue this policy and hope that the Chairman will work with us to remove the obstacle put in place by OBRA '93.

CONCLUSION

Fiscal necessity and pragmatism clearly show that government cannot and should not try to assume the entire long term care burden. Private sector ways and means must be harnessed in partnership with public programs and resources. In order to form the required partnership, Congress should seek to maximize the role of private long term care insurance through: federal standards and consumer protections; tax clarification for long term care insurance products; and public education.

AHCA is pleased to see that the President's health care reform legislation includes these measures.

For the required long term care private/public partnership to succeed, the Congress must avoid: over-regulation of long term care insurance; disincentives to appropriate and cost-effective long term care placement; expectations for government programs that those programs cannot meet; overcommitment of federal and state fiscal resources; obstacles to the establishment of state private/public long term care partnerships; and lack of clarity between public and private roles.

AHCA is committed to working with Congress and the Administration to help avoid these potential policy problems.

AHCA is pleased that the Clintons, the Congress, and the public are discussing long term care in the context of health reform—and we are pleased to have been included in that conversation. Thank you for your attention and your consideration.

Senator KASSEBAUM. I will start my questions with you, Dr. Willging, since you finished up last. Just to follow on what you said a bit, so you are saying you do not think that a long-term care benefit should be part of any mandated basic benefit package?

Mr. WILLGING. I think that what the President has in his basic benefit package, which is the 100 days for nursing facility, hospice, or home care, is an important part of the cost containment mechanism. But I think a new Federal program, or even Federal-State program, which would cover all individuals regardless of financial eligibility and regardless of age, does in fact place too much emphasis on the public sector.

Senator KASSEBAUM. One of the things that I have felt, though, was important is that my children in their 30's should carry long-term care insurance, because you cannot wait until you are 70 and wonder if you should start carrying it, or if it is too late. And most young people do not think about it, no matter how much you might talk to them about how important it is; they sometimes do not really even believe they need health insurance, let alone long-term care insurance. But unless you spread the risk out over a large enough portion of the population, I think, then you do not have the ability to offer premiums that do not become so costly.

So I was curious as to how you feel about that.

Mr. WILLGING. You are absolutely correct, Madam Chairwoman. In fact, I have a long-term care insurance policy that I purchased at the age of 49. I will not say how many years ago that was for fear of divulging things that I think should be intimately private. But I pay about \$400, \$500 per year. Now, if I were to wait until I were 70 or 75, I would be paying \$1,000 or more for that same policy.

Unfortunately—and that is why this provision for consumer education is so important in the President's bill—the last thing people want to think about is the fact that at some stage, they will become old, they will become potentially debilitated, and they will need long-term care services. We do not like to think about that sort of thing.

Senator KASSEBAUM. Well, I agree, and plus, it is not just the elderly.

Mr. WILLGING. Exactly.

Senator KASSEBAUM. There are those who have a lifetime of care, and that always troubled me in the catastrophic legislation, because it addressed just Medicare-eligible. And I remember visiting with Senator Weicker about it at the time, and he said, "Well, let us get this step done first, and then we will take the other."

I think that it is very important not to overlook that. Now, how we put this together, I am not sure. Actuarially, it gets difficult to even put a parameter of cost estimates on it. But I think nevertheless, with all of us who have the expertise—and that is not here, with us; it is there, with you—working on this together, maybe we can find some of the answers.

Mr. WILLGING. But to buttress your contention, you are absolutely correct. Ten percent of the residents in our facilities are

below the age of 65. People think of nursing facilities as exclusively residences for the elderly. That is not true, and in fact, it is becoming more and more across the entire spectrum of age spans.

Senator KASSEBAUM. Just a question perhaps to both of you. I have visited a number of nursing homes, and there tends to be quite a difference between Medicaid-eligible patients in a nursing home and Medicare. And I think it is actually harder and harder to find care facilities for Medicaid-eligible today. Is this because there is a reimbursement differential there that makes it that much more difficult?

Dr. Willging. You put your finger on it. Quite frankly, to provide the levels of service we wish to in nursing facilities, it is important that the costs be reimbursed. The laws of economics have not been repealed for nursing facilities. Generally, it is estimated that the Medicaid program provides 70 to 80 percent of the costs of providing a day of care in a facility. To be able, therefore, to maintain those high standards of quality, we have, quite frankly, an insidious form of taxation in this country. We charge the private-pay patient more money so as to subsidize the inadequacy of the reimbursement under Medicaid. And the end result is one has to maintain a balance in a facility of Medicaid and private-pay patients or, in the case you reference, Medicare versus private-pay patients versus Medicaid patients.

Senator KASSEBAUM. And that is why those rates for private-paid insurance are much higher than other rates.

Mr. WILLGING. Exactly.

Senator KASSEBAUM. So there is cost-shifting there that takes place just as it does in hospitals.

Mr. WILLGING. It is true across the entire spectrum of publicly-funded health care entities. I am sure it is also true in the home care arena, just as it is in hospitals and nursing homes. Government has not been willing, for whatever reasons, to belly up to the bar and pay its fair share of the costs of providing care.

Senator KASSEBAUM. Well, we try and keep costs down, and, as was pointed out by Mr. Halamandaris—I am sorry I keep stammering over the pronunciation—in that we sort of rob Peter to pay Paul and do not seem to recognize what we are doing at the time.

Just one last question. The Boren amendment, as you know, was designed to require State Medicaid payment be reasonable and sufficient to ensure that beneficiaries have access to care. How diligently do you think that the Department of Health and Human Services enforces those requirements in the process of reviewing proposed State Medicaid plans?

Mr. WILLGING. Madam Chairwoman, I was deputy administrator of the Health Care Financing Administration as my last position as a Federal civil servant, and I was a Federal civil servant for 13 years and proud of every one of those 13 years. But I can guarantee you in my 10- or 11-hour days, I perhaps spent, if I did, one percent of my time worrying about whether or not these States were adequately paying health care providers.

Quite frankly, the Federal Government does not adequately test the degree to which States are paying—and thank God for the Boren amendment, because although I know it creates consternation sometimes in State Government—and indeed, in Kansas, we

have had a Boren suit—but all the Boren amendment says is that States shall pay the costs of the efficient and economically operated facility. That is kind of like God and motherhood. What is the alternative? States shall not pay the costs of the economically and efficiently operated facility? That is probably not the case.

I think what we have to do is recognize that we have a demographic explosion in this country and that unless we do in fact foster the development of private sector resources, States are going to constantly be whipsawed. The only ones who will be whipsawed by this demographic explosion.

If we do nothing, Madam Chairwoman, that 48 percent which is picked up by Medicaid in terms of costs, revenues, going into the nursing home facility industry, will grow to 67 percent by the year 2025. If we stimulate long-term care insurance, we could see that potentially dropping to 33 or 34 percent. We have got to change the way we do business in this country in terms of financing long-term care.

Senator KASSEBAUM. Mr. Halamandaris, you addressed very well the recommendations to reduce Medicare and Medicaid funds, and yet on the other hand, adding back in new benefits. I would just like to ask you in general again how adequate are the Medicare reimbursement rates for home care compared to private insurance.

Mr. HALAMANDARIS. Well, you put your finger on a very important question, and I suggest it has a root cause in the basic nature of the two programs, Medicare and Medicaid.

The Medicare program is an entitlement program, and as you know as well as anyone, the Medicaid program is a welfare program and therefore suffers from the stigma that one has to take the pauper's oath to get it, one has to go through this elaborate spend-down process in order to qualify for it. And therefore, individuals who receive it carry that stigma, and they are treated differently by people who interact with them.

It is just unfortunate, but that is a fact of life. It is one of the reasons why a lot of us have argued for an entitlement program, that what we ought to be doing here is saying health care is a right for all Americans, and the right to life, liberty and pursuit of happiness, freedom of press, religion, speech, means nothing without the right to health care. It is the penultimate or the ultimate right, and I do not think you limit that right when you start talking about long-term care.

So as far as the issues of compensation and reimbursement, the Medicare program, because it is uniform across the country, tends to do a little better job of accurately reflecting costs. As we know, States are under such enormous pressures, and their budgets right now are very taxed, and a large part of that taxing relates to the Medicaid program. So they are really struggling under it, and there is a temptation to cut.

So I agree with what Paul is saying, that the temptation there is to reduce the level of reimbursement, which does have an effect on the quality.

Senator KASSEBAUM. Do you see growing home care requests today versus what might have existed 15 years ago? Do you see a public that perhaps is wishing to have that as a more attractive alternative?

Mr. HALAMANDARIS. Yes. In all the surveys that we have done, the American public prefers to remain in their own homes, if possible. When that is not possible, of course, they want the best possible institutional care available to them.

It is interesting to note that approximately half of the people that we serve in home care are under age 65, and the fastest growing part of long-term care we should reflect is, first of all, the elderly because of demographics—and more and more of them will come in need of services as we have beaten back mortality. That is the good news. The bad news is that there has been a concomitant increase in disability; those people who live longer are going to need more services. The services that they want are services that allow them to remain in their own homes as much as possible.

The other end where we are seeing a tremendous increase in long-term care is among very young children. Pediatric home care is the fastest growing part of our business, and that is as a result of another blessing. The blessing is the technology that has allowed us to save the lives of babies who previously died.

I am old enough to remember when 3 pounds was the absolute demarcation line; then it went to 2 ½ pounds; and then if you were 2 pounds, you lived; and then it was a pound and a half. And now, because of the technology, we routinely save children who are less than one pound. Well, the technology makes that possible, and that technology until recently did not exist, and then only in a hospital. And now it has been miniaturized so that technology allows the care of those children in the crucial time of their lives at home. Sometimes, in order to save them, the technology damages their lungs, and as you know, they become dependent on a ventilator, a device to help them breathe. And sometimes for 6 months or a year or longer, they are dependent on the machinery. That, of course, is so much less costly to be delivered in the home setting as opposed to a hospital setting, and it certainly is preferred. You can just imagine yourself what it would be like to go to the hospital every day to see your baby for a year or a year and a half while the baby develops and gets to the point where it can come home with you, as opposed to having that child at home where it could be with its other siblings and its family. The disruption and the stress are just mind-boggling, to say nothing of the costs.

So there is tremendous pressure to increase home care services at both ends, the elderly and the very young members of society. Then we have a number of wonderful examples of disabled individuals today who suffer accidents or have various other disabilities, who are looking for home care services themselves. So the need will increase exponentially as time goes by, and we hope that we are up to that need.

The one thing that I have by way of concern is can we continue to bring into our industry adequately trained and qualified personnel who are adequate to meet the needs that are there. In this country, whether it is nursing homes or home care or hospitals, we rely primarily on home care aides. No health care system is any better than the people who deliver those services. We put so much on these people, and yet they are paid the minimum wage, and many of them do not even have health care. So this is a real trag-

edy that we have to address, and I do not know totally what the answers are, but we do have to address it.

Senator KASSEBAUM. I certainly agree. I know that in Kansas, there is a growing number of young men and women who are entering LPN acute care programs through either vocational-technical schools, schools of nursing, and that entry-level positions are beginning to receive some recognition of the importance of some of that basic care. Individuals can advance from entry-level positions. I think there are going to be good-paying jobs there, and there need to be; I certainly would agree with you.

Did I ask you if you saw a growing demand in insurance policies that cover long-term care in one way or another?

Mr. HALAMANDARIS. You did not, but I certainly agree.

Mr. WILLGING. Well, in fact, it has been almost exponential—speaking of which, here is the Health Insurance Association of America, and I will use some of her lines, because I know them as well as she does.

This has been almost exponential. Ten or 15 years ago, we had half a dozen companies selling—well, I think probably about 10 years ago, we had 50,000 policies that had been sold. Now we have 135 companies which have sold up to 2.9 million policies.

What is also interesting, Madam Chairwoman, is the growing sophistication of these policies. It used to be early on they would exclude more conditions; you had to have a prior institutional stay before you could use home care; some did not even have home care. I think these policies now reflect the fact that long-term care is a continuum and that these policies should reflect the entire continuum.

Did I do an adequate job on that, Susan?

Ms. VAN GELDER. Absolutely. The only word you did not use was that the products have changed lightyears since introduced in 1986.

Senator KASSEBAUM. It is a pleasure to have Susan Van Gelder as a witness.

Ms. VAN GELDER. And I do apologize. I am terribly sorry for being late.

Senator KASSEBAUM. Susan is deputy director of policy development and research for the Health Insurance Association of America.

Perhaps you would like to offer closing comments, and your full statement will be made a part of the record.

Ms. VAN GELDER. Sure. I am happy to be here on behalf of HIAA, and we look forward to working with the committee on any kind of long-term care financing proposals that you put forth. And we certainly hope that they embrace some kind of public-private partnership.

Senator KASSEBAUM. I think that was the gist of the testimony that has been offered, and we were exploring, first, the rapid growth in the need for long-term care. Second—I would ask you, do you think, though, that long-term care should be a mandated benefit in a basket of benefits?

Ms. VAN GELDER. Should long-term care be a mandated benefit?

Senator KASSEBAUM. Right.

Ms. VAN GELDER. In terms of privately mandated, or through Government?

Senator KASSEBAUM. Well, we are assuming that if you look at the President's plan, it would be a health alliance structure, and the insurers would be the participants in offering that basic basket of benefits to all parties. And I think even in other plans, where we would not have a health alliance structure, but voluntary co-operatives, long-term care is addressed as a benefit that is regarded as very important.

Ms. VAN GELDER. Yes. I believe in President Clinton's plan he calls for in the basic benefit package some very limited, almost Medicare skilled nursing care type benefit—100 days and some home health care.

Senator KASSEBAUM. In my concept, I would require it as a full benefit offered to everyone, because I think my children should have to take it. They are not at the age of 30 going to think they need to take it, and if it is going to work as a benefit, it seems to me you have got to bring a large percent of the population in.

Ms. VAN GELDER. I see. Well, the employer market has certainly been growing in leaps and bounds, so I think you are discussing how to get it into the employer market among younger people.

Senator KASSEBAUM. Right.

Ms. VAN GELDER. Yes. That is worth consideration.

Senator KASSEBAUM. And I was asking the prior witnesses just as you came forward if they saw an increase in policies being taken that offer long-term care, and particularly by a younger age group, I would hope.

Ms. VAN GELDER. Well, the average age of the employee purchasing is about 40, 43 right now. Over 400 employers have offered such coverage through the end of last year. And the average premium at age 43 is about \$200 a year for a fairly decent policy. So that does hold the most promise in really protecting people against long-term care.

The notion of it being mandated is something worth considering; I think we will go back and talk about that at HIAA.

Mr. HALAMANDARIS. Madam Chairman, a final comment, if I may. Someone with good intentions is going to suggest that the total solution to long-term care should lie in allowing individuals to purchase private long-term care insurance. I would say that that would be a drastic mistake; that we have to have a public and private partnership. There is a wonderful role that long-term care insurance can play, and let us encourage people to buy that insurance. I support your idea of a mandate; I think it is an excellent idea. Otherwise, it really will not work.

Senator KASSEBAUM. Well, I myself have been very reluctant to have either the administration or Congress determine what is in a benefit package. But the one benefit that it seems to me is important to be in there is long-term care, because otherwise I think you put it off, and growing costs are out there, and Dr. Willging, you gave the figures of what it is going to look like even within the next decade. Kansas ranks above Florida in the percent of the population over age 85. But it is not just age, as I pointed out earlier. I think we need to take that into consideration. Demographics are

changing; we just cannot ignore that as we look at medical and insurance needs, I think.

Thank you very much. Do you have any other comments, Ms. Van Gelder, that you wish to make?

Ms. VAN GELDER. No, Senator, and I apologize again for not being informed when the hearing was.

Senator KASSEBAUM. Well, I think you were not slighted; I think that all three of you probably share some similar thoughts here.

Thank you very much. I appreciate it.

[The prepared statement of Susan Van Gelder follows:]

PREPARED STATEMENT OF SUSAN VAN GELDER

Good morning Mr. Chairman and Members of the Committee. My name is Susan Van Gelder and I am Deputy Director of Policy Development and Research Department at the Health Insurance Association of America (HIAA). HIAA represents approximately 270 private insurance companies providing health insurance for 65 million Americans. About 62 percent of the long-term care insurance policies sold have been issued by member companies.

HIAA welcomes the opportunity to testify today on the issue of long-term care in the context of the Administration's health care reform proposal, The Health Security Act. Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform of our current system. Furthermore, we believe that comprehensive reform of our nation's health care system must include measures which promote a strong public-private partnership in the financing and delivery of long-term care services.

Uninsured people under the age of 65 represent only half the problem of inadequate health insurance protection. Almost 32 million Americans over the age of 65 also face the potentially devastating financial exposure to catastrophic expenditures for long-term care services. If our nation is serious about comprehensive health care reform, we must not abandon our nation's older and disabled Americans.

HIAA believes that the current health care reform debate provides an important opportunity to improve our country's long-term care financing system. We believe that this system best can be improved through three strategies. First, individual responsibility in planning for exposure to long-term care risk must be promoted through consumer education. Consumers must be made aware of the risk of incurring catastrophic expenses, the wide array of long-term care services and settings offered, and the numerous types of private insurance products available to finance these services.

Second, the growth of the private long-term care insurance market must be fostered by educating consumers about long-term care risk and product options and providing tax incentives for purchasing coverage. Tax clarification would increase the affordability of these products, lend additional legitimacy to this coverage and help millions of Americans protect themselves against catastrophic long-term care expenses.

In conjunction with tax clarification, we would support establishing minimum Federal standards for long-term care insurance products that would serve as a "seal of approval," thereby building consumer confidence in private long-term care products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. Equally important, consumers should be allowed to purchase federally-approved policies in all states. Separate state approval should not be necessary. In fact, HIAA believes that a requirement for separate state approval would limit consumers' access to a wide range of high quality products by stifling competition in the long-term care market.

Third, HIAA believes that public assistance must be provided for those who are unable to finance their own long-term care expenses. Such assistance could take the form of enhancements to the Medicaid program.

We are pleased to see that the Administration has included several provisions in the Health Security Act which are consistent with both HIAA's goals for strengthening financial protection for long-term care services and our strategies for achieving these goals. Such provisions include clarifying the tax status of long-term care insurance products; implementing minimum federal standards; authorizing consumer education grants for the development of long-term care information and counseling

programs; increasing the Medicaid asset threshold for single individuals from \$2,000 to \$12,000; and raising the personal needs allowance for Medicaid recipients of institutional care.

We have two concerns with the newly proposed national home care program. First, HIAA believes that a far better use of limited tax dollars would be to target care to those unable to protect themselves, and encourage those who can afford to do so, to purchase private protection. Second, we are concerned that the Administration will "sell" the public on this program as a down-payment toward a national solution to long-term care when even this modest home care benefit is estimated to cost \$65 billion over five years. Costs alone dictate that the ultimate solution must be a public-private partnership. It is critical that the Administration clarify to the public that this program is not an entitlement program and that individuals will continue to bear significant responsibilities in financing community-based services.

Mr. Chairman, the testimony below will focus on HIAA's views on the importance of addressing long-term care financing issues as part of health reform and our recommendations on how long-term care financing improvements can best be accomplished. We will comment specifically on the long-term care measures incorporated in the Health Security Act and the legislation you currently are drafting, the Life Care Act. Because HIAA is awaiting comments on the recently released legislative language of the Health Security Act, however, we hope the Committee would be receptive to more detailed comments after HIAA and its members have had time to do a more thorough review.

I. LONG-TERM CARE IN THE CONTEXT OF HEALTH CARE REFORM: THE HEALTH SECURITY ACT

In his speech before Members of Congress on October 27, President Clinton reiterated the six fundamental principles on which his reform plan is based. At least four of these principles are relevant to long-term care reform: security, quality, choice and responsibility. These principles are among those included in HIAA's own Vision for Reform which we constructed last year. I'd like to elaborate on these principles briefly as they pertain to long-term care.

Security

The risk associated with older Americans incurring catastrophic long-term care expenses is equal to the risk to younger Americans of incurring costly primary and acute care expenses. The majority of those requiring such services are 65 or older. Approximately 7.1 million of the 32 million people age 65 and older need long-term care assistance. Seventy-nine percent of this group lives in the community with assistance and 21 percent live in nursing homes.

It is estimated that people age 65 face a 43 percent chance of entering a nursing home sometime during their lives. Of those who do enter nursing homes, 34 percent will have lifetime use of up to five years; 21 percent will experience lifetime stays of five years or more and incur enormous expenses to cover their care. Fully half of the age 85 plus population today needs some assistance with activities of daily living (ADLs) due to chronic illness or disability. Others need assistance with activities such as shopping, housekeeping and managing medication and finances (instrumental activities of daily living or IADLs). Since the over 85 age group is the fastest growing segment of our population, the needs of our nation's oldest citizens can only continue to grow.

The cost of long-term care services can be financially devastating. The average annual cost of nursing home care nationally is about \$36,000 and can be over twice this amount in certain areas of the country. Community-based services such as home health care also can impose significant financial burdens on the disabled, averaging \$10,000 to \$15,000 annually for someone who needs assistance several times a week.

Clearly, demographic and fiscal trends suggest the need for immediate action to address the long-term care financing needs of our nation's elderly. Despite heightened media attention in recent years to the long-term care needs of older Americans and their families, increased awareness has not resulted in a coordinated approach to our long-term care system. Delivery of these services remains fragmented and financing can be extremely complex. Furthermore, access to appropriate long-term care services often is blocked by inadequate financial protection.

As you know, Mr. Chairman, the Medicare program was never intended to fund long-term episodes of illness for the chronically impaired. Furthermore, individuals must impoverish themselves to become eligible for Medicaid. Access to community-based support under Medicaid is limited and varies tremendously from state to state.

Public benefits for long-term care provide older Americans very little security. A survey published this year by the Employee Benefits Research Institute (EBRI) suggests that the American public is more confused than ever about what the Federal government does and does not pay for long-term care expenses. In fact, an even greater percentage of 1993 EBRI survey respondents indicated that they believed Medicare would pay for their long-term care expenses than those responding to the 1990 survey. These findings underscore the need for the federal and state governments to clarify their roles in financing long-term care and educating the public about how public and private sector responsibilities should be shared in funding this care. Only through such clarification and education will older Americans and their families find true security relative to their long-term care needs.

Individual Responsibility

In outlining the major principles underlying the Administration's plan for health care reform, President Clinton consistently has stressed the importance of individual responsibility by stating that "every American must assume responsibility to bring an out-of-control system under control and put funding on a fair and responsible basis." HIAA believes this principle also must be applied to the long-term care side of the health care equation, and that the public and private sectors must share responsibility for financing long-term care services. Clearly, given the magnitude of long-term care expenses, the government, private industry, and individuals all must share the costs of this burden. Both the federal and state governments are staggering under the pressure of increasing budget constraints. The cost of financing long-term care services, particularly in institutional settings, accounts for a large part of these constraints.

In recent years, the private insurance industry has spearheaded efforts to enhance financial protection for long-term care services. Currently 125 companies offer long-term care insurance coverage. Since 1987, the number of individual policies sold has almost quadrupled, from 815,000 policies sold in December of 1987, to 2.9 million at the end of 1992. Of the policies sold in 1992, 32 percent were employer-sponsored policies. Moreover, the products themselves have changed light years since first introduced to the market.

HIAA analyzed policies of the top fifteen long-term care writers, representing 80 percent of the market of all individual and group association policies sold in 1991. All products analyzed offered coverage for skilled, intermediate and custodial nursing home care as well as home health care services. Thirteen of fifteen companies offered adult day care, 60 percent covered alternate care and 40 percent offered coverage of respite care benefits. All companies offered inflation protection, two-thirds offered nonforfeiture benefits and many companies introduced new benefits. (See Figure I for prototype coverage offered in 1991).

It is important to note that consumers themselves are beginning to recognize the need to share responsibility for long-term care risk. A 1990 EBRI study indicated that 43 percent of the respondents felt that the Federal government should accept primary responsibility for financing long-term care costs; only 6 percent felt that individuals should play the primary role. By 1993, only 29 percent of the respondents to EBRI's long-term care survey felt the Federal government should have primary responsibility for this burden. About 17 percent felt that individuals should play the primary role and another 13 percent felt that this should be a family responsibility.

Public opinion regarding willingness to pay for private long-term care insurance further supports the notion of individual and family responsibility for financing long-term care costs. About 65 percent of respondents indicated that they would purchase a policy from a carrier or employer. Almost 60 percent said they would purchase a policy for a family member, such as a spouse, parent, grandparent or child. In addition, respondents to the 1993 survey indicated a willingness to pay significantly more for private coverage than respondents to the 1990 survey. On average, 1993 respondents indicated they would be willing to pay \$927 annually for long-term care insurance. Respondents to the 1991 survey said they would pay, on average, \$488 annually.

Choice

A fourth principle underlying the Health Security Act is choice. HIAA believes that one of the most valuable benefits accruing to those who purchase private long-term care insurance is choice—the ability to exercise control over which of the many community-based, residential and institutional services available they wish to use—and the ability to select which providers will deliver the services they choose.

While asset protection is an important reason for purchasing long-term care coverage, it is not the most important reason cited by those who buy policies. In a survey of 14,000 policies purchased in 1990, over half the respondents cited the most

important reasons were preserving their independence (30 percent) and being able to afford needed care (20 percent). Protecting assets was cited by only 14 percent as the most important reason for obtaining coverage.

Clearly, individuals who are dependent on public assistance have few choices. The options they do have are conditioned to a large degree upon their state of residence and the state's economic status since federal Medicaid matching funds are determined by the amount states are able to contribute. The development of innovative long-term care insurance plans, and access to this coverage, clearly expands the range of choices consumers have in meeting their long-term care needs.

Private long-term care insurance helps consumers preserve this choice. The continuous expansion of product benefit features has enabled consumers to select among a vast array of options relative to health care services and settings. For example, the HIAA survey revealed that 60 percent of the top fifteen sellers offer some type of alternate care benefit enabling consumers to receive nontraditional benefits such as special medical care (e.g., services provided by special care units for Alzheimer's Disease); home modifications that enable consumers to remain at home instead of entering an institutional setting (e.g., modifications to bathrooms and kitchens, installation of wheelchair ramps); and care in adult foster homes and assisted living settings. Care management and caregiver training benefits also are being offered as a free-standing benefit by some insurance companies to help older people negotiate the complex web of long-term care services and settings and to train their caregivers to provide services enabling them to remain at home longer.

Quality

A principal goal of the Health Security Act is to improve the quality of care delivered to the American public. HIAA believes that access to private long-term care insurance coverage enhances consumers' access to high quality care in at least two ways.

First, private markets create greater incentives for providers to deliver high quality care in order to compete for clients. Second, by expanding the number of individuals paying privately for nursing home and community-based care, it will increase the amount of resources available to long-term care providers and assist them in maintaining high standards of care.

The expansion of private financing for long-term care services also reduces the drain on federal and state Medicaid budgets, a factor that has the potential to improve the adequacy of public reimbursement rates. Since Medicaid nursing home rates on average compensate providers for only about 70 percent of the actual costs of care, enhanced public reimbursement will help guarantee quality care.

II. CONSUMER PROTECTION STANDARDS

A. HIAA Consumer Protection Standards

HIAA and its members share the objectives of policy makers and consumers—strong consumer protection laws and their full enforcement are needed for long-term care insurance. The market will not survive without them. To emphasize the need for unique consumer protection standards in the area of long-term care, in 1991, HIAA adopted a Proposal for Long-term Care Consumer Protection which states the Goals of Long-Term Care Insurance Consumer Protection Regulations and proposes a Consumer "Bill of Rights". It identifies fundamental consumer rights for the purchasers of long-term care insurance. To back up the Bill of Rights, the proposal recommends a series of specific provisions in the areas of company, agent, and consumer education; disclosure; marketing practices; and policy benefit provisions. (See Attachment A).

HIAA believes that the cumulative effect of government regulation should be to create an environment where the benefits of regulation outweigh their costs for consumers, the private sector and government. There are multiple provisions in the current NAIC Model Act and Regulation which HIAA firmly supports as appropriate consumer protection. These include:

- Requirement that individual policies be guaranteed renewable.

- Required offer of inflation protection.

- Prohibition against post-claims underwriting.

- Requirement that insurers establish auditable marketing standards, for fair and accurate comparisons of policies, notification of limitations of coverage, and notification of availability of senior counseling programs if one exists in the state.

- Prohibition against prior-hospitalization requirements.

- Required 30 day free look period with full refund of paid premiums upon return of policy within this period.

Penalties on agents and insurers equal to three times the commission rate, or \$10,000, whichever is greater.

Required delivery of detailed outline of coverage.

Required coverage of Alzheimer's Disease.

Prohibition of preexisting condition exclusion period of longer than six months.

Minimum standards for home care, including prohibitions against tying benefits for home care to the need for skilled nursing care, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.

Prohibition against conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

Requirement that group policies provide for continuation and conversion.

Loss ratio requirements at least equal to 60 percent for individual policies.

Prohibition against twisting, high pressure sales tactics and cold lead advertising.

Requirement that agent determine appropriateness of a recommended purchase prior to sale.

Required delivery of buyers' guide prior to sale.

In addition, there are several provisions in the HIAA Consumer Protection Framework which go beyond the current NAIC Long-Term Care Model Act and Regulation. They include:

Require insurers to establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.

Require insurers to establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.

If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.

Require policies to waive premiums while the insured is receiving nursing home benefits.

Require insurers to establish and maintain a meaningful update protection program offering policyholders new policy forms, improvements and coverages currently marketed by the insurer.

Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care which accounts for the inability of the insured to perform an appropriate number of activities of daily living; or a similar level of disability as can be measured in terms of medical necessity; or a similar level of disability due to cognitive impairment.

Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point of sale.

Require insurers to inform an applicant about coverage decisions within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.

Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.

Require insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves. In addition, the NAIC should, working with insurers, develop criteria for evaluating insurer reporting data.

Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

B. Provisions in Health Security Act of Concern to HIAA

HIAA supports the President's intent to provide consumers high quality long-term care insurance products that assure consumers good value and adequate protection. We believe that the standards outlined above provide consumers with such assurances. We are concerned, however, that some of the standards contained in The Health Security Act are overly prescriptive and could act as a disservice to consumers. The concerns regarding specific provisions outlined below are based on a preliminary reading of the Act. Our comments are listed in order of their appearance in the legislation and are not ranked according to HIAA's priorities. (The page numbers after each section pertain to the Health Security Act). HIAA would appreciate the opportunity to provide the Committee with additional comments after we have analyzed this new legislation more extensively.

1. Section 2303—Relation to state Law (p. 430)

This section would allow states to apply standards that exceed minimum federal standards.

HIAA believes that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market. Many long-term care insurance sellers have dropped out of the market due to the administrative burden and expense of filing different policies in fifty separate states. The increase in administrative costs resulting from multiple filings and approvals of the same product increase premium costs needlessly.

HIAA recommends requiring insurance companies to file and receive approval for products only in their state of domicile. Findings of compliance with minimum federal standards in the domiciled state would then enable a carrier to sell its product in any state. Such a policy would benefit consumers by increasing the number of carriers selling long-term care insurance products, expanding the type and number of products available to consumers, reducing the time lag between product filings and product availability in the market place and lowering the costs of products. Furthermore, the broadening of competition in the market place would act as a powerful incentive for insurance companies to offer high quality, competitively priced products.

2. Section 2321(b)—Uniform Terms (p.435)

The Health security Act would require insurers to use inform terminology, definitions of terms, and formats in long-term care insurance policies.

HIAA recognizes that in order to provide meaningful benefits, policies must have clearly understood and well defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition developed. Beneficiaries could be harmed if definitions are "locked in" prematurely.

An example of the difficulty in having uniform definitions of terms pertains to assisted living facility benefits. Different states and provider organizations use different criteria in defining assisted living facilities. The type of services provided in these settings may range from meals and housekeeping only to assistance with personal care. Regulations regarding the type of licensed or nonlicensed personnel required to provide services in these settings differ across states. Yet both of these care settings may be referred to as "assisted living."

HIAA believes that it is important to maintain flexibility in defining certain terms in long-term care policies. This would allow companies greater latitude in offering a variety of benefits under long-term care insurance policies as both the insurance market, and the continuum of long-term care services, continue to evolve.

3. Section 2321(c)(2)(D)—Premium Limitations (p. 437)

Under the standard outline of coverage for long-term care policies, carriers would be required to include a statement of the total annual premium and the portion of such premium attributable to each covered benefit; and any limit on annual premium increases.

HIAA strongly supports reasonable and justifiable insurance premiums which ensure that a carrier's long-term care obligations will be met. We share the Administration's concerns that consumers be protected from unwarranted rate increases. To that end, we believe the most effective protections include measures which assure that initial premiums, and potential increases, are determined appropriately on the basis of actuarial data. However, we oppose the establishment of arbitrary limits on premium increases and do not believe that such limits would achieve the goal of ensuring that rates are set correctly in the first place. In addition, such limits have the potential to threaten insurers' abilities to pay future claims which is certainly not in the best interest of consumers.

To assure that consumers are protected against unfair rate increases, and to promote the establishment of accurate rates at the outset of premium pricing, HIAA recommends the following measures be taken:

Prohibit insurers from selling policies with premium schedules based on attained age rating and durational rating.

Require insurers to report their total long-term care premiums earned, claims incurred and loss ratios by state and in total to each state annually to provide states with the data needed to accurately assess the viability of premium pricing assumptions and methods.

11Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves to ensure that adequate resources will be available to pay all claims.

Require insurers to meet an expected loss ratio of at least 60 percent for individual policies. In addition, the NAIC, working with the industry, should deter-

mine the effects of lapse rates and underwriting practices on the pattern of loss ratios.

Require insurers to provide rate guarantees for three years from the date policies are issued. In addition, rate increases should be limited to 10 percent for insureds over age 75 who have maintained coverage for 10 years or more.

Require carriers to provide insureds the opportunity to reduce the level of benefits covered under the policy 90 days prior to a rate increase. This would enable consumers to maintain premium levels no higher than those in effect prior to a rate increase.

Implement sanctions against insurers who demonstrate excessive rate increases. HIAA recommends that in cases where carriers increase rates by more than 50 percent in any three year period, they should be prohibited from issuing policies for a period of two years in the state where rates were increased in excess of this limit.

Permit state insurance commissioners to modify or waive rate provisions which could jeopardize solvency. For example, rates may need to be modified in the event of changes to federal and state laws or based on medical breakthroughs or new disabling diseases that would result in changes to mortality and morbidity patterns or assumptions.

4. Section 2321(c) Comparative Coverage (p. 440)

Under the outline of coverage, carriers would be required to provide consumers with comparative information regarding the availability of other private insurance including benefits offered under other long-term care policies offered by the insurer; additional benefits available under wider policies offered by other private carriers; and information regarding each public long-term care program administered by the state, Medicare programs under title XVIII of the social Security Act and each regional alliance operating in the State.

HIAA supports the right of consumers to receive accurate and thorough disclosure which enables a prospective insured to accurately assess the benefits and limitations of long-term care insurance coverage. We also support requirements that insurers provide consumers with a state-approved long-term care insurance consumer guide; the address and phone number of the state insurance department with the name and number of an insurer home office contact; and, if such a program exists, the name, address and phone number of a state-approved senior insurance counseling program. This information should be provided at the time of policy solicitation.

HIAA is concerned, however, about requirements to provide additional information required under the Health Security Act, such as information about competitors' insurance products and detailed information about federal and state public programs, including benefits available under regional alliances. These reporting requirements are excessive, burdensome and, quite frankly, unachievable by any private or public sector entity.

5. Section 2324(d) Agent Compensation (p. 448)

Directs Secretary of HHS to establish limits on agent compensation.

HIAA does not support the use of agent compensation restrictions. We believe that problems with regard to lapse rates and replacement rates should be dealt with more directly by regulating agent sales and marketing practices and extensive agent training and education. Caps on commissions will not remove incentives for unwarranted initial sales or ill-advised policy replacements. Blanket restrictions on sales commissions do not distinguish between agents selling in an ethical, responsible way and those who do not. The job of regulators is, and should continue to be, the effective enforcement of laws designed to weed out and prevent abuses—not the creation of laws which indiscriminately restrict appropriate competition across the board.

Long-term care insurance is still a relatively new market around which a great deal of consumer ignorance and misunderstanding still exists. The sale of this product involves educating consumers about the need for long-term care protection, the service options available and individual product options. Dedicated agents should not be penalized for spending the extra time necessary to assist consumers in understanding their long-term care needs and options.

6. Section 2326(b)(2)—Independent Professional Assessment (p. 463)

This section would provide for an independent assessment of benefit eligibility by a qualified independent assessor selected by the insured.

HIAA objects to an independent third party determining eligibility for private policies. While we advocate that there be a strong appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage an individual's long-term care needs so that the best care can be delivered most effi-

ciently. Transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities.

7. Section 2325(e)—Mandatory Nonforfeiture (p. 457)

This section would mandate nonforfeiture benefits.

HIAA supports the concept that insurers must be required to offer all prospective policyholders, including group policyholders, a nonforfeiture benefit in the event of non-payment of premium. This should bear a reasonably consistent relationship by issue age and duration. We do not support mandated nonforfeiture benefits in policies because of the resulting premium increases associated with this benefit and questions regarding the value this benefit to those required to purchase it. HIAA also disputes the validity of the reasoning behind a mandate for nonforfeiture benefits. Nonforfeiture benefits presumably are needed due to high lapse rates among long-term care insurance policyholders. Yet data collected by HIAA regarding lapse rates indicates that 50 percent of so called lapses are due to deaths and internal or external replacements; i.e., consumers replacing existing coverage with a newer policy offered by the same carrier or with a policy offered by a different carrier.

A mandatory nonforfeiture benefit presents serious equity problems because it would substantially increase premiums for the majority of policyholders. An HIAA analysis based on data prepared for the NIAC indicated that, for a cohort of policyholders, only 30 percent would benefit from a reduced paid-up nonforfeiture benefit. The other 70 percent would be forced to pay additional premiums, but never receive any benefit. According to an HIAA analysis of several of its members' long-term care products, a reduced paid-up nonforfeiture benefit increased the average annual premium for a 55 year old by 30 percent and, for a 60 year old, 20 percent. A nonforfeiture benefit which returns premium upon lapse raised the average annual premium for all ages by roughly 40 percent.

HIAA also questions the value of nonforfeiture benefits relative to the costs, and whether this strategy is the most effective vehicle for addressing the problem it is intended to cure—voluntary lapse of insurance policies. Like life insurance, long-term care policies must be in force for a certain period of time before substantial benefits would accrue to the lapsed policyholder. Since most consumers who let their policies lapse do so in the first two years of coverage, there would be no value—only cost—to requiring nonforfeiture benefits. Policyholders who maintain their policies would not need nonforfeiture protection. Finally, if educated consumers fully understand the benefits and limitations of nonforfeiture, they should be given the option to purchase such protection.

HIAA feels that a more appropriate solution to the problem of policy lapses is to assure that consumers understand the need for and value of long-term care insurance protection, make educated choices about the purchase of products and that agents are well-trained to assist consumers in making prudent choices. HIAA supports agent education and includes such provisions in our Consumer Protection proposal. We also support the establishment of consumer education grants as specified in the Health Security Act.

8. Section 2346—Failure to Have Approved State Program

This section would prohibit insurers from selling policies in a state that does not have in effect an approved state regulatory program.

HIAA objects to this provision which would penalize insurance carriers and consumers for state violations of federal law. HIAA recommends that carriers be permitted to sell in any state as long as their products comply with minimum federal standards. Such a policy would encourage carriers to comply with minimum federal standards regardless of state implementation and enforcement activities. It would assure consumers access to a wide range of products that meet minimum federal standards.

III. TAX CLARIFICATION

HIAA applauds the President for including tax clarification in his health care reform proposal. The current uncertain tax treatment of long-term care insurance is a hindrance to market acceptance and raises the price of the product. Clear tax rules will add legitimacy to, and further the establishment of, the long-term care insurance market. The expansion of this market will have the parallel effect of reducing future costs to the public sector.

We also are very pleased that the Administration's proposal contains provisions which clarify the tax status of life insurance policies that accelerate benefits on account of terminal illness and long-term care. Since accelerated benefits were introduced in the early 1980's, we have sought clarification of the federal tax issues surrounding these products, which are now offered by more than 150 insurers and owned by approximately three million policyholders. As a result of this clarification,

policyholders will be able to utilize their life insurance policies without adverse tax consequences to assist them in dealing with extraordinary medical expenses.

HIAA also supports the provision of tax credits for employed persons with disabilities. This provision would enable impaired taxpayers to take a non-refundable tax credit equal to 50 percent of certain impairment-related personal assistance services.

HIAA agrees with most of the tax clarification provisions in the President's bill. There are, however, a few items which HIAA feels the Committee should modify:

HIAA feels that the maximum benefit amount excluded from taxation of \$150 per day beginning in 1996, indexed for inflation, is too low. In many areas of the country, particularly large urban centers, \$150 is insufficient to cover the costs of nursing home care. HIAA would suggest that the maximum benefit amount be set at \$250, indexed for inflation, to assure that consumers who live in higher cost urban settings are not penalized based on geographic location.

There are a number of other changes that HIAA would suggest. Many states now require companies to use a one-year preliminary term reserve. However, the IRS permits companies to deduct reserves no faster than over a two-year period. HIAA feels Congress needs to conform the tax code to state regulatory requirements.

Many companies now permit covered employees to enroll their parents under their plan. To help encourage this trend, HIAA recommends, for the purpose of long-term care insurance payments, that parents be treated as dependents.

Finally, the effective date of many of the tax clarifications in the Health Security Act is December 31, 1995. HIAA sees no reason it could not be sooner, perhaps December 31, 1994, to help consumers afford protection as quickly as possible.

IV. NEW HOME AND COMMUNITY BASED SERVICE PROGRAM

HIAA has two concerns with the newly proposed national home care program. First, we believe that a far better use of limited tax dollars would be to target care to those unable to protect themselves. Scarce federal and state resources should be preserved for the needy rather than promising all Americans a small amount of coverage. Individuals who can afford to purchase private insurance coverage should be encouraged to do so through education and tax incentives. Educational programs, such as those that would be available under the proposed consumer education grants, should assist consumers in understanding the risk of catastrophic long-term care expenses and options for covering this risk. Tax incentives should be used to increase the affordability of long-term care products. Furthermore, the establishment of tax incentives would lend additional legitimacy to long-term care products and increase consumer confidence in such products.

Second, HIAA questions the viability of this new community-based service benefit and is concerned that there is great potential for consumers to misconstrue their right to this benefit and overestimate the amount of protection it provides. Our primary concern regarding the viability of this program relates to funding. Even this modest benefit is projected to cost \$65 billion and funding for the program is contingent upon extremely ambitious projections regarding cost savings under current federal programs—including \$65 billion in new Medicaid savings.

HIAA also believes that there is great potential for the public to misunderstand the coverage provided. Although the legislation does not provide an entitlement to specific services or benefit levels, there is ample evidence of public misperceptions regarding federal long-term care benefits to warrant concern. To wit, the 1993 EBRI long-term care survey indicates that a higher percentage of respondents to this survey (45%) thought that Medicare would pay for their long-term care expenses than respondents to EBRI's 1990 survey (35%)—despite the tremendous media attention to the long-term care problem in recent years.

Further, HIAA does not believe that the funding allocated to this program will provide substantial coverage for home care services to a broad segment of the population. Since income caps and age limitations are removed, we believe that many more individuals will qualify for benefits than states will have funding to cover, even under the enhanced federal match rate. In addition, while the program is targeted toward the severely impaired, HIAA is concerned that the public will not understand the eligibility limitations placed on the program and will overestimate the coverage provided. In the absence of broad-based public education, it is extremely likely that consumers will underestimate their ongoing need for private coverage of these services.

HIAA also is concerned that the structure of this program will lead to confusion among consumers regarding their coverage. The program calls for the use of both public and private financing to cover the same home and community-based services. Until an individual is severely disabled, their community-based services would be

financed under a private insurance policy. Once they became severely disabled, they would discontinue private coverage and begin receiving public benefits for these services. Receipt of public benefits, however, would be contingent upon the availability of state funding for these services. Furthermore, except in the wealthiest states, such as New York, it is questionable whether consumers would receive the same level of community-based benefits under the new public program as they would have received under their private insurance policy. In such cases, the consumer might need to maintain the private insurance policy to supplement the cost of services not covered by the public program.

The structure of the home care program hardly creates the kind of "seamless" system touted by the Administration. To the contrary, it creates the potential for tremendous confusion on the part of consumers. It also presents challenges to insurance companies attempting to structure a private insurance benefit that coordinates with public coverage. If each state has the discretion to establish its own benefit package for home and community-based services, insurance carriers will need to develop a different home care benefit for every state to coordinate with public benefits. Furthermore, to maintain currency with state programs, carriers would have to update their home care benefits each time states modified their programs, restructure premiums to account for changes in actuarial assumptions and pricing, and refile new products with state insurance departments.

HIAA is concerned that the administrative and financial burdens placed on carriers under the Administration's proposed program structure would force carriers to reconsider the viability of offering home care coverage. Surely, this is not in the best interest of consumers who consistently have expressed their preference for this type of coverage in national surveys. For these reasons, HIAA strongly recommends that eligibility for the new home and community-based service program be income-related and that private insurance be encouraged for those who can afford this coverage.

V. THE LIFE CARE ACT

HIAA has reviewed a draft of the Life Care Act which would establish a program of voluntary public insurance for nursing home benefits. HIAA believes that the intent of the Life Care Act is inconsistent with the Health Security Act which maintains a system of private health insurance for those who can afford to purchase such coverage. We submit that insurance to cover long-term care expenses also should be provided by the private sector for those who can afford this coverage. We have a number of concerns regarding both the intent and structure of the Life Care Act, including the following:

Financial Risk: The Life Care Act includes no underwriting requirements to access this new benefit; i.e., anyone who applies for coverage will be accepted unless they already are in a hospital or nursing home. Eligibility for coverage is set at one impairment in ADLs or IADLs or cognitive impairment. This type of access renders the program an open-ended entitlement program—not an insurance program. The absence of underwriting and the inclusion of extremely liberal benefit eligibility criteria will make it extremely difficult to establish accurate premiums for coverage and puts both the government and individual beneficiaries at extreme financial risk.

Consumer Shortfalls: HIAA believes that the program will penalize consumers by subjecting them to extremely volatile premium rates, discriminating against consumers who live in high-cost areas and limiting their choice of providers under the reimbursement structure of the program.

Standards for Public and Private Programs: This program discriminates against private insurance policies by holding public sector insurance programs accountable to a lower standard. In addition, the structure of this public program would make it virtually impossible for private insurers to design private programs that coordinate coverage with the public program.

Program structure: The role of the government is to provide for the public good when such assurances cannot be provided by the private sector. There is no evidence of market failure in the private long-term care insurance market. There are no incentives to promote private sector expansion or the development of a strong public/private partnership in financing long-term care services. Furthermore, this program will require the establishment of a massive new bureaucracy to administer the program. HIAA does not believe that this is the best use of scarce public resources.

A. Financial Risk

HIAA is concerned that the Life Care Act puts the public sector at severe financial risk since there is no underwriting required by this program and the eligibility criteria are extremely lax. Anyone who applies for this coverage would be eligible

unless they were confined to a hospital or nursing home at the time they became eligible for coverage. Even then, these individuals would qualify for coverage 90 days following discharge from the hospital and six months following discharge from a nursing home. The absence of underwriting criteria raises two concerns. First, it shifts excess risk to the public sector since private insurance companies would not cover individuals who already were disabled. Second, it would be virtually impossible to establish accurate premiums for this risk since the absence of underwriting takes this program out of the category of insurance and places it under the category of an open-ended entitlement program.

The minimum standards for eligibility based on mild functional impairment in activities of daily living or instrumental activities of daily living and mild cognitive impairment further exacerbates the pricing problem. These eligibility criteria differ substantially from both private policies and public benefits proposed in other legislation introduced to date, including the Health Security Act. Most recent bills have established an eligibility standard of at least three ADL impairments for nursing home and home care benefits. The rationale for a home care eligibility standard of three ADLs has been that home care benefits should be funded only for those who otherwise would qualify for nursing home care. Individuals who are disabled in only one ADL or IADL do not need nursing home care.

HIAA questions the viability of a public or private sector program using such lax eligibility criteria. Almost 20 percent of the over 65 population have difficulties in performing at least one activity of daily living or instrumental activity of daily living. This number increases with advanced age and reaches almost 57 percent for those age 85 or older. These data suggest that a significant proportion of the population would qualify for the nursing home coverage starting at age 65. When eligibility based on cognitive impairment is added, the number qualifying would be even higher. For example, 22 percent of the over 80 population would qualify on the basis of cognitive impairment alone. Data from insurance companies indicate that moving from eligibility criteria requiring disabilities in three out of six ADLs to one out of six would increase premiums 40 percent.

The combination of minimum eligibility standards with no underwriting requirements would put the federal government and individual consumers at severe risk. The federal government risks underestimating the cost of premiums for this program and having insufficient resources to pay claims. Individuals are at risk of dramatic increases in premiums to offset the higher than expected costs of programs. One might also raise the question of what guarantees consumers would receive at the outset of the program. Would the Federal government impose rate caps on itself, as has been proposed for the private industry, such that consumers would be guaranteed a ceiling on rate increases? Would the Federal government guarantee noncancellable policies for individuals over a certain age, say 75?

Finally, HIAA requests clarification of the eligibility standard requiring that an individual need assistance for at least 100 days to qualify for benefits. Is this determination made at the onset of a spell of illness or does this provision mean that there is a 100 day waiting period before benefits begin? If the answer is the former, what happens if the assessor guesses wrong and the person does not need assistance for the full 100 days? Is the client penalized for collecting benefits that they ended up not qualifying for? HIAA also recommends clarification of the eligibility standard requiring that nursing home care be in the best interest of a consumer. Consumers have the right to know upon purchasing the public benefit how the Federal government will determine what is in their best interest.

B. Consumer Shortfalls

HIAA does not believe that the Life Care Act is in the best interest of consumers for several reasons. First, as mentioned above, unless the Federal government is willing to accept risk for underestimation of premiums and program costs, premium stability would be extremely compromised. In fact, consumers would have greater assurance of premium stability under private insurance policies since these products use underwriting and more reasonable eligibility criteria to control risk and provide an actuarially sound basis for setting premium rates. We believe that it is highly unlikely that the Federal government would provide noncancellable coverage (i.e., lifetime premium guarantees) because it would jeopardize the solvency of the federal budget and place other publicly funded programs at risk of extinction.

Second, this legislation does not account for geographic differences in the cost of nursing home care and actually discriminates against consumers that live in high cost areas. The program would reimburse individuals on the basis of reasonable costs defined as "the average cost of providing appropriate care in the most efficient manner". A person purchasing \$30,000 worth of coverage in New York will receive

about half the amount of benefits, measured in duration of coverage, as a person in Kansas where the cost of care would be less than half the cost in New York.

Private insurance policies provide consumers more choice in the selection of providers and allow them to take into account geographic variables. Consumers select the level of daily benefits they choose to purchase and their lifetime coverage increases in proportion to the daily benefit elected. Furthermore, consumers can choose to elect higher benefit levels to account for differences in costs among various providers, so that their insurance benefits provide adequate coverage for the provider of choice.

Third, the Life Care Act contains no specific options for upgrading benefits over time. Accordingly, consumers electing coverage at age 45 have no assurance that the lifetime benefit they purchase at the time of election will be adequate to cover the cost of care. Nor are there options for nonforfeiture of benefits in the event that consumers decide to lapse their policies.

Fourth, in order to qualify for benefits, it must be determined that nursing home care is in the best interest of the consumer. HIAA does not believe that an independent agency should have the ability to make such a decision for a consumer, especially when that consumer has paid for a benefit he or she expects to obtain upon meeting the clinical eligibility criteria. The insurer or an organization affiliated with the insurer is contractually obligated to manage an individual's long-term care needs. This would assure efficient delivery of services. Reliance on a third part assessment could expose the insurer to unintended claims liabilities.

C. Standards for Public and Private Sector Programs

The Health Security Act establishes minimum standards for private long-term care insurance products which mirror, to a large degree, the standards established by the National Association of Insurance Commissioners. The rationale for these Federal standards is that consumers do not receive adequate assurances of protection under state insurance regulations since all states are not current with the NAIC standards. The Life Care Act includes no reference to standards that would have to be met by the Federal government in the provision of long-term care insurance benefits.

HIAA strongly objects to having private insurance policies held to a higher standard than the government is willing to hold itself accountable to under a public program. The Life Care Act provides consumers none of the guarantees that must be provided under private insurance programs. For example, while private policies must guarantee offering inflation protection of at least 5 percent compounded annually and nonforfeiture benefits, the Life Care Act provides neither assurance. While the NAIC is working toward rate stability standards and the Health Security Act requires private insurers to disclose at the time of sale the maximum amount by which premiums can rise annually, the Life Care Act includes no such protection. Further, although the Life Care Act would enable consumers to protect additional assets in the amount of their public insurance benefit and qualify for Medicaid, consumers would not receive the same protection if they choose to purchase private coverage instead of the public benefit.

D. Program Structure

HIAA believes that the role of government is to protect the public good in cases where the private sector has demonstrated an inability to ensure the public good. Clearly, there has been no such private market failure in the long-term care insurance arena. As indicated earlier, the availability of long-term care insurance has grown dramatically since 1987. Not only have the number of insurance companies offering such coverage increased over five-fold, but the number of policies sold has also been rising steadily at an average annual rate of 30 percent during the same period. The products themselves also have evolved substantially. The most burdensome limitations found in earlier products such as prior level of care requirements have been eliminated and a series of new benefits such as assisted living facility and alternate care coverage have been added. Consumers now have access to a broader range of group and individual products with a wide array of benefits.

For these reasons, HIAA would argue that there is a strong private market for long-term care insurance products. The establishment of a public program for this coverage would be duplicative and has the potential to undermine the viability of the private market.

The duplication of nursing home coverage in the public sector also would be confusing to consumers. Eligibility criteria and reimbursement policies for private products differ significantly from the standards proposed in the Life Care Act. Since payment for nursing home care under private insurance (where such insurance exists) would be required before the public benefit became available, however, and the eligi-

bility criteria differ, it would be confusing for consumers to determine which coverage to use at which times. For example, assume a person was receiving public insurance for a spell of illness triggered by one ADL impairment. If the person's disability level increased to three ADLs during the same spell of illness, and he/she had a private policy covering long-term care services for those disabled in three or more ADLs, would the public program cease to provide benefits when the person reached three ADLs until the private coverage was exhausted? And when the private coverage was exhausted, would the individual then revert back to coverage under the public insurance program?

In addition to creating confusion for consumers, the nursing home benefit proposed in the Life Care Act would make it extremely difficult for commercial carriers to develop a product that provided "wrap around" protection to fill in the gaps and serve as a complement to public coverage. This difficulty is based on a number of factors such as differences in eligibility standards between the public and private programs, differences in the amount of public benefit provided based on cost variances attributed to geographic location and provider selection, reduced consumer demand for long-term care insurance and great uncertainty regarding the role of private insurance under the Life Care Act.

HIAA also questions the wisdom of establishing the complex new bureaucracy that surely would be needed to administer such a program at a time when public resources are being stretched to the limit and when the Congress and Administration presumably are intent on reducing health care administrative costs. Since the private sector is providing consumers the needed protection against long-term care risk, the creation of such a bureaucracy would seem to be a blatant and needless waste of scarce public resources.

Finally, despite recognition by the majority of policy makers that the demographic and fiscal variables indicate the necessity of a public/private sector solution to the long-term care financing dilemma, the Life Care Act includes no incentives to foster such a partnership. The absence of such incentives is not merely shortsighted but, in fact, a serious threat to sound fiscal policy and consumer protection against long-term care risk.

HIAA urges the Committee to examine carefully the viability of the Life Care Act and to consider public/private sector alternatives that protect the public good in the broadest sense and provide consumers meaningful choices in the selection of long-term care protection.

CONCLUSIONS

HIAA applauds the President for introducing an ambitious blueprint for reform of our nation's health care delivery and financing system. We further are encouraged that he recognizes the need to address long-term care in his vision for reform through the establishment of a strong public/private partnership in long-term care financing. Clearly the magnitude of the financing dilemma suggests the need for such a partnership to ensure access to long-term care services for all Americans.

HIAA believes that our current long-term care financing system can best be enhanced through three strategies. Individual responsibility in planning for long-term care risk must be promoted through education. The development of a strong private long-term care insurance market can be facilitated through tax incentives that increase the affordability of long-term care products and lend legitimacy to this market. Federal standards, in conjunction with tax clarification, can further increase consumer confidence in long-term care products and spur market growth. Finally, for those who are unable to finance their own long-term care services, a humane program of public assistance must be provided.

HIAA is pleased that the Administration has included several provisions in The Health Security Act which are consistent with HIAA's goals and strategies for promoting long-term care protection. These provisions include clarifying the tax status of long-term care products; establishing federal minimum standards; authorizing consumer education grants for long-term care information and counseling; and amending the Medicaid program to allow for higher asset thresholds and by raising the personal needs allowance for the institutionalized.

The Health Insurance Association of America would like to serve as a resource to Members of Congress and the Administration in refining proposals to improve our country's system for financing long-term care services. We stand ready to assist the Committee in this process in the coming months.

Figure 1
Typical Coverage Offered by 1991 Leading Sellers*

Services Offered	Skilled, Intermediate, and Custodial Nursing Home (15 out of 15) Home Health Care (15 out of 15) Adult Day Care (13 out of 15) Alternate Care (9 out of 15) Respite Care (6 out of 15)
Death Benefit	\$40-120/Day Nursing Home \$20-60/Day Home Health Care
Benefit Eligibility**	Medical Necessity Only (4 out of 15) Medical Necessity or Needing Assistance in ADLs or Cognitive Impairment (10 out of 15)
Maximum Benefit Period	Unlimited Nursing Home (13 out of 15)
Alzheimer's Disease Coverage	Yes (15 out of 15)
Deductible Periods	0-20 Days and 90-100 Days
Renewability	Guaranteed (15 out of 15)
Preexisting Condition	6 Months or Less (15 out of 15)
Inflation Protection or 5% Compound for Life	Yes (13 out of 15)
Nonforfeiture Benefit	Yes (10 out of 15)
Age Limits for Purchasing	50-84 **
Waiver of Premium	Yes (15 out of 15)
Free-Look Period	30 Days (15 out of 15)
Marketing	Company or Independent Agents

* Based on 15 companies that represent 80 percent of all policies sold in 1991.

** One company used medical necessity and needing assistance in ADLs or cognitive impairment.

Source: HIAA, 1992

ATTACHMENT A

HIAA PROPOSAL FOR LONG-TERM CARE INSURANCE CONSUMER PROTECTION (Adopted by the HIAA Board of Directors, April 26, 1991) (Amended by LTC Task Force, 5/21/92)

The Health Insurance Association of America (HIAA), the trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans, strongly believes that the insurance industry can play a vital role in financing the nation's long-term care bill. The nature and cost of long-term care make reliance on the private sector both appropriate and practical.

In order to develop and grow successfully, however, insurers must provide long-term care insurance products which provide meaningful and affordable protection to their policyholders. Policies must also be marketed and sold by educated and trained individuals. HIAA recognizes that in order to reach its full potential, there is an exceptional need to protect consumers who purchase this type of private insurance product. This particular need is unique to long-term care insurance products and should in no way be considered appropriate for other types of health insurance.

To strengthen consumer protection regulation, the purpose of this proposal is to recommend specific regulatory measures for adoption by the states, through enforcement of existing laws, or where current authority is inadequate, through enactment of new laws or adoption of additional insurance department regulations. More specifically, this proposal sets forth the following:

I. The goals of meaningful consumer protection regulation;

II. The fundamental tenets, or rights, that long-term care insurance consumers should be guaranteed; and

III. Specific consumer protection provisions, or standards, which are aimed at guaranteeing that these basic consumer protection rights are achieved.

The specific consumer protection provisions supported under Section III were considered primarily with the individual market in mind. This section includes a discussion, however, of additional consumer protection provisions which are necessary in group long-term care insurance markets. Lastly, the proposal discusses the equally critical need for effective enforcement mechanisms to ensure that consumers are protected by the very laws designed to do so.

Taken together, HIAA believes that this proposal offers a sound approach to protecting purchasers of long-term care insurance policies, creates an appropriate state regulatory framework for effectively regulating the market, and recognizes the critical role that enforcement must play to ensure a successful regulatory process.

I. GOALS OF LONG-TERM CARE INSURANCE CONSUMER PROTECTION REGULATION

HIAA believes that the cumulative effect of government regulation should be to create a regulatory environment where the benefits of regulation outweigh their costs for consumers, the private sector and government. Based on this overall objective, HIAA believes that the following goals form the basis for developing meaningful consumer protection regulation.

1. Increase consumers' knowledge about long-term care and financing options available to them.

2. Provide consumers, regardless of where they live in the U.S., access to long-term care policies which provide meaningful benefits at a reasonable price.

3. Recognize the need to maintain strong consumer protection while encouraging insurers to develop fair and innovative benefits in an evolving marketplace.

4. Link regulatory standards to appropriate enforcement mechanisms to ensure their effectiveness.

II. FUNDAMENTAL LONG-TERM CARE INSURANCE CONSUMER RIGHTS

In developing a consumer "Bill of Rights", HIAA was guided by the overriding concern that consumers be guaranteed a "good value" when they purchase a long-term care insurance policy. Although this term has yet to be defined adequately by regulation or otherwise, we believe that we have taken a solid first step in this direction by identifying fundamental consumer rights and the specific provisions which must be implemented in order to ensure these rights. These fundamental rights are:

1. Consumers have the right to accurate, complete and clearly written information about long-term care and long-term care insurance policies.

2. Consumers have the right to trained and educated agents who respect their clients' trust and would never do anything which would betray that trust or confidence.

3. Consumers have the right to policies which provide meaningful long-term care benefits.

4. Consumers have the right to a fair and thorough explanation, in written form, of all the requirements they must meet to qualify for benefits.

5. Consumers have the right to a fair and understandable application process and once insured, they have the right to a fair and equitable claims payment process which is communicated clearly in written form.

6. Consumers have the right to policies which are at least guaranteed renewable.

7. Consumers have the right to reasonable and justifiable premiums over the life of their policies and the right to expect an insurer will have the financial capacity to meet all future claim obligations.

8. Consumers have the right to effective state enforcement of laws created to achieve these consumer protection rights.

III. APPROPRIATE CONSUMER PROTECTION PROVISIONS

To ensure that the fundamental consumer protection rights are achieved, HIAA identifies below specific regulatory standards which should be adopted by state legislatures or regulators. We have also made recommendations for states to improve their data collection, monitoring and enforcement relating to the long-term care insurance market. Irrespective of the specifics of legislation regulating long-term care insurance, HIAA believes that the principles discussed below represent a comprehensive regulatory approach to ensuring that the public's best interests are protected in this marketplace.

1. Consumer Right: Accurate and Thorough Disclosure

A. Require insurers to provide consumers a uniform description of the policy that will allow them to clearly understand benefits, limitations, and other plan provisions and will facilitate comparison among different policies. The policy description must include all significant benefits and limitations of the policy including types of care covered, deductible periods, maximum benefit periods, pre-existing condition exclusions, noneligible providers and types of care, inflation protection options, renewability, coverage of Alzheimer's Disease, and premiums.

B. Require insurers to provide consumers with a state-approved long-term care insurance consumer guide.

C. If such a program exists, require agents to provide consumers with the name, address and phone number of a state-approved senior insurance counseling program at time of policy solicitation.

D. Require agents to provide the address and phone number of the state insurance department and the name and phone number of an insurer home office contact.

2. Consumer Right: Appropriate Insurer and Agent Sales and Marketing Practices

A. Require insurers to establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.

B. Require insurers to establish marketing procedures which ensure that if any comparison of policies is made by agents, that the comparison be a fair, complete and accurate one.

C. Prohibit insurers and their agents from the marketing practices of "twisting", high pressure sales tactics, and "cold lead" advertising.

"Twisting" refers to knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

High pressure sales tactics refers to employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

"Cold lead" advertising refers to making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

D. Require insurers to establish criteria for agents to follow in making reasonable efforts to determine the appropriateness of new, additional or replacement policies

E. Require insurers to establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.

F. Require insurers to establish auditable procedures for verifying compliance with marketing and sales practices and training and education programs.

G. Require states to include testing on long-term care insurance as part of the general health and life licensure process.

H. If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.

I. Depending on a state's existing advertising requirements, require insurers to retain a copy of any long-term care insurance advertisement intended for use whether through written, radio or television medium for at least three years from the date the advertisement was first used. Such advertisement shall be available for review by the state insurance department upon request.

Or, require insurers to provide a copy of any long-term care insurance advertisement to the state insurance department for review or approval to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer for at least three years from the date the advertisement was first used.

J. Require insurers to give insureds an opportunity to return their policy for any reason and receive a full refund for up to 30 days after receiving their policy.

K. If a policy is returned during the 30-day free-look period, require insurers to refund premiums promptly and in accordance with state law.

3. Consumer Right: Policies Must Provide Meaningful Benefits

For purposes of this section, a long-term care insurance policy is defined as:

Any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid or other bases; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. With regard to life insurance, this term includes those policies which accelerate the death benefit specifically for the receipt of long-term care.

Specifically:

A. Policies must provide at least one year of long-term care benefits.

B. Policies may offer home health care and other noninstitutional benefits. To support the insured's desire to remain at home, at a minimum, home health benefits cannot:

Be conditioned upon the receipt of nursing and/or therapeutic services before other home health care benefits are covered; limit services to those provided by R.N.s or L.P.N.s to provide services that other appropriate personnel could provide; require that benefits be based on an acute condition or be provided only in lieu of skilled nursing home care; and limit providers to those certified by Medicare.

C. Policies must cover all levels of nursing home care—skilled, intermediate and custodial—if nursing home benefits are provided in the policy.

D. Policies cannot exclude coverage for insureds who develop Alzheimer's Disease and other related organically-based dementias.

E. Policies cannot employ preexisting condition limits which are more stringent than:

A condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of the policy. Coverage for a loss or confinement which is the result of a preexisting condition cannot be excluded from coverage unless such loss or confinement begins within six months following the effective date of the policy.

F. Policies must waive premiums while the insured is receiving nursing home benefits after a period of receiving such benefits not to exceed 90 consecutive days. (Not applicable to policyholders residing in CCRCs.)

G. Insurers must establish and maintain a meaningful update protection program. Insurers issuing long-term care insurance on or after the date of enactment shall offer policyholders, including group policyholders, new policy forms,

improvements, and coverages currently marketed by the insurer to the same class of policyholders.

A meaningful update program shall offer every policyholder, including group policyholders, policy improvements currently being marketed to the same class which have not previously been offered to that policyholder. The frequency of the offering to any class shall be at least every 5 years. The offer must be made without subjecting the insureds to new preexisting conditions or other limitations on existing coverage. Rates and underwriting shall not be more restrictive than for new issues. No update protection offer need be made to any person receiving benefits and/or not pay premiums.

Policy improvements that must be offered: removal of exclusions for coverage of Alzheimer's and related dementias; removal of prior institutionalization requirements; adding nonforfeiture protection; adding inflation protection; adding or expanding home care coverage; changing the policy to guaranteed renewability; and eliminating restrictions for payment of only certain levels of care.

HIAA recognizes that in order to provide meaningful benefits, policies must have clearly understood and well-defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition yet developed. As a result, insurers have struggled to provide a comprehensive description of a heretofore undefined and evolving delivery system. In defining policy benefits, insurers have attempted to address consumer concerns of provider quality as well as insurer concerns that expected utilization be reasonable in relation to premiums. To further improve this situation, HIAA recommends that:

H. If policies include the following terms, they must be appropriately and clearly defined: skilled, intermediate and custodial nursing home care; nursing home; home health care; adult day care; elimination period; waiting period; and maximum benefit period.

I. Insurers must offer all prospective policyholders, including any group policyholder, optional inflation protection features. At least one inflation option offered must increase the daily benefit 5 percent annually on a compounded basis over the lifetime of the policy, including any period of time the insured is on claim. If insurers only offer policies with inflation protection features, they need not also offer ones without them.

J. Insurers must offer all prospective policyholders, including a group policyholder, a nonforfeiture benefit in the event of nonpayment of premium. The nonforfeiture benefit must maintain a reasonably consistent relationship by issue age and duration. The insurer must disclose the amount of the nonforfeiture benefit for each policy or certificate anniversary to the state insurance department. Examples of nonforfeiture benefits include, but are not limited to, a reduced paid-up benefit, extended term insurance, a return of premium and a cash surrender value. If insurers only offer policies with nonforfeiture benefits, they do not have to offer a policy without such a benefit.¹

4. Consumer Right: Appropriate and Understandable Benefit Eligibility Criteria

A. Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care. Insurers shall include in their contracts at least one of the following criteria: Insureds are determined to be disabled due to an inability to perform an appropriate number of activities of daily living (ADLs), or insureds have a similar level of disability based on the medical care required, or insureds have a similar level of disability due to cognitive impairment.

B. Require insurers to provide a clear and thorough explanation of their benefit eligibility criteria in the policy contract. All significant terms such as ADLs, the need for assistance in ADLs, medical necessity, and cognitive impairment must be defined.

C. Require insurers to provide a clear and adequate written definition of the benefit eligibility process at the point of sale.

D. Prohibit insurers from conditioning long-term care benefit eligibility upon prior hospitalization or prior nursing home confinements. In addition, prohibit insurers from conditioning the use of non-skilled nursing home or noninstitutional benefits upon the prior use of skilled level benefits.

¹This provision does not apply to policies where each policy year's attained age premium is expected to provide for that policy year's morbidity risk.

5. Consumer Right: Fair and Understandable Application Process; Fair and Equitable Claims Payment Process

A. Require insurers to develop clear and unambiguous questions on the application form designed to ascertain the health condition of the applicant.

B. If the application form asks about prescribed drug use, the insurer must also ask the applicant to list the medications prescribed. Insurers are prohibited from later rescinding the policy if the listed medications are related to medical conditions that would have resulted in disapproving the applicant for coverage.

C. Insurers must inform the applicant in clearly written form that incorrect or untrue responses on the application form may lead to denial of benefits or rescission of the policy.

D. Insurers must collect further medical history information, such as a report of a physical exam, an assessment of functional capacity, an attending physician's statement, or copies of medical records, for all applicants age 80 and over.

E. Insurers must return the completed application form to the insured no later than when the policy is delivered.

F. Insurers must inform an applicant whether he/she is accepted for coverage within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.

G. Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.

H. Require insurers to report well-defined and meaningful claims experience data to each state annually.

6. Consumer Right: Guaranteed Renewable Policies

A. Require insurers to guarantee that long-term care policies cannot be canceled unless the policyholder terminates the contract by nonpayment of premiums.

B. Require insurers to either: provide at least a three-month guaranteed reinstatement period for policyholders who miss a payment because of reduced competence, or offer at the time of application the opportunity for the insured to designate an alternative individual to be notified if a premium is not received by the premium due date.

7. Consumer Right: Reasonable and Justifiable Premiums; Long-Term Care Obligations Will be Met

A. Prohibit insurers from selling policies with premium schedules based on attained age rating and durational rating. Such a prohibition however, should not limit insurers' rights with regard to rate adjustments under guaranteed renewable contracts. Nor should such a prohibition limit the ability of insurers to develop plan designs, especially in the employer market, which base premiums on some structure other than entry age level premiums.

B. Require insurers to report their total long-term care premiums earned, claims incurred and loss ratios by state and in total to each state annually.

C. Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves.

D. Require insurers to meet an expected loss ratio of at least 60 percent. The NAIC, working with the industry, should determine the effects of lapse rates and underwriting practices on the pattern of loss ratios.

8. Consumer Right: Effective Enforcement

A. Insurer Data Collection, Reporting and Monitoring

1. Require insurers to report the following information to each state annually: agent and insurer replacement, lapse and rescission rates; and the number of policies sold and in-force. Data reported are subject to all applicable privacy laws. Such agent specific data shall not be required until it reaches a credible level.

2. The NAIC, working with insurers, should develop criteria for evaluating insurer reporting data.

3. To the extent current law permits, consumers have the right to receive reporting information required in this section from the states upon request.

B. State Enforcement

1. Require states to establish specific monetary penalties on agents and insurers for violations of sales and marketing laws. These penalties shall be in the form of a fine of up to three times the amount of any commission paid for each policy involved in a violation, or up to \$10,000, whichever is greater.

2. Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

Consumer Protection Unique to Some Long-Term Care Markets

The consumer protection provisions described in the previous pages of section III were developed primarily for the individual long-term care insurance market. While this market constitutes the bulk of the market today, other types of products are developing rapidly. For example, about 25 percent of all individuals who became insured in 1990 were in the employer market. Group association policies available to members of continuing care retirement communities are also growing.

In addition, there are several recently developed life insurance products which will advance the policy's death benefit based on certain triggering events, including long-term care. While the latter are primarily life insurance products, to the extent they specifically provide long-term care insurance protection, they are subject to this proposal.

Because of important differences from the individual market, there are several consumer protection provisions which should be adopted for group long-term care policies. For purposes of this proposal, a group refers to the four different groups defined in the NAIC model act, Section 4E. Special consumer protections which state governments should adopt include:

1. A continuation and Conversion Requirement

Group policies are designed to provide similar protections to guaranteed renewable individual policies. This is achieved by the insurer offering individuals the right to have their group coverage continued or by issuing a conversion policy whenever coverage would otherwise terminate—including discontinuance of the master group policy.

Insurers selling group long-term care insurance policies should follow the continuation and conversion requirements as specified in the NAIC model act and regulation to guarantee that individuals purchasing long-term care policies under group arrangements have protections similar to those provided by a guaranteed renewable individual policy.

2. Extraterritorial Jurisdiction for Discretionary Groups Group long-term care coverage may be made available to individuals who are members of groups which are approved by state insurance departments because these groups result in economies of scale, the benefits are reasonable in relation to the premiums charged, and formation of the group is not contrary to the best interest of the public (i.e., Section 4E (4) of the model act).

To adequately protect consumers purchasing policies under this group arrangement, insurers should be required to abide by the requirements of Section 5 of the NAIC model act. This provision provides that no long-term care coverage may be offered to a resident of a state under a group policy issued in another state to a "discretionary" group unless the former state (or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the former state) has made a determination that such requirements have been met.

3. Agent Sales and Marketing Practices

When an insurer uses licensed agents to sell a group product, then all the consumer protection provisions in Section III addressing agent sales and marketing practices in the individual market should apply to insurers selling these products as well.

There are some unique consumer protection provisions which should be considered specifically for the employer-sponsored group market. Historically, employers have secured health care benefits for employees and their dependents based on what they believe is in their employees' best interests. This has resulted in insurer, employer, and often employee negotiations that affect policy design, benefits, and premiums.

Employers typically use actuarial consultants, benefit managers and a competitive bid process (often required of government employers), to help design the policy's benefits and to evaluate initial and renewal rates. Employer-sponsored group plans are also subject to separate state laws regarding initial rate filings. They are typically class rated or experience rated based upon the employer's actual claims experience and they are subject to financial accounting and group rating laws.

Because of these differences, some provisions recommended for the individual market should be modified to strengthen their intent and effect in the employer-sponsored group market. For purposes of the following provisions, employer-sponsored group policies refer to those policies issued to a group as defined in Section 4E (1) of the model act. These provisions include:

1. Consumer Disclosure Requirements

As stated above, employers and organized labor have traditionally selected and determined welfare benefits for both employees and their dependents. As a result, many of the consumer disclosure requirements in the individual market take on a different format and process in the employer group market.

For example, a description of the policy's benefits, limitations, and other provisions are usually determined by the employer, rather than the insurer. Similarly, employers often determine the format of how information is provided to their employees. This may or may not include the use of a specific consumer guide. Requiring that a state-approved consumer guide be provided to every employee, as specified for the individual market, is not necessarily effective or efficient.

However, to assure that employees and their dependents receive similar information to that received by persons buying policies in the individual market, insurers should provide employers information which is equivalent to that provided in a state-approved consumer guide. Moreover, because the specific provisions required in the outline of coverage for individual policies are not entirely adequate or accurate for persons purchasing policies in the market, insurers should provide the following disclosure information to be included in the enrollment material:

- Description of long-term care.

- Why long-term care insurance is being offered.

- Cost of long-term care.

- Need for long-term care.

- Current methods for paying for long-term care.

A notice that eligible employee, retiree or family members may be eligible for coverage from other sources, such as an employer medical plan, Medicare, or Medicaid.

- Description of principal plan features, including:

- Coverage of family members

- Covered conditions and exclusions

- Benefit eligibility

- Waiting periods/deductibles

- Evidence of insurance requirements

- Inflation provisions

- Preexisting conditions

- Continuation and conversion coverage

- Cost of coverage

In addition, certificates issued under the group contract should include:

- Description of principal benefits and coverages

- Statement of exclusions, reductions and limitations

- Statement that the group master policy determines governing contractual provisions.

In addition to these written materials, employers generally hold meetings and other educational forums during the enrollment period so that employees have the opportunity to learn about a long-term care benefit. Recognizing these employer activities, this proposal supports the NAIC model act, Section 6F, which excludes employer groups from having to provide a 30-day free-look period after the enrollment process.

Lastly, because employers are responsible for the creation of all written, radio, television, and other materials about their long-term care insurance product, insurers should not be required to file such materials with state insurance departments for approval, (if a state has such a requirement for the sale of individual health insurance products).

2. Preexisting Condition Limits

To date, most employer-sponsored group plans have provided policies to active employees with no underwriting or knowledge of the employee's medical history. Under these conditions different preexisting condition limits are necessary to take the place of medical underwriting and to avoid using a high premium rate that is otherwise necessary to cover uninsurable conditions. Recognizing this difference in the employer group market, this proposal supports the NAIC model act, Section 6C, which excludes employer groups from the preexisting condition requirements established for other long-term care insurance products.

STATE ENFORCEMENT OF LAWS IS EQUALLY CRITICAL

HIAA recognizes the unique market that long-term care insurance products serve and believes that state enforcement of all health insurance laws is particularly critical for this product. Long-term care insurance is subject to a host of state health insurance laws which affect product design, advertising, and sales and marketing practices. These laws, combined with the additional provisions we recommend in this paper, should all be used to protect consumers of long-term care products. Equally important are the states' commitment to effective monitoring and enforcement.

The company data reporting requirements, state imposition of monetary penalties, and state reporting of violations recommended in section 111(8) of this proposal will significantly enhance current state enforcement activities. These provisions require that a number of key data elements be reported to the states and that insurers and states work together to develop criteria to evaluate such data. We believe this approach encourages "good" companies to stay in the market and provides states the additional information they need to monitor the market and effectively protect consumers.

HIAA continues to support more punitive enforcement measures as well. Monetary fines specifically for insurers and agents selling long-term care products should be implemented and states should make public those entities found in violation of a state's long-term care insurance laws or regulations.

In the absence of a systematic approach to improving the current enforcement process, regulators will act on anecdotal stories, not solid evidence, to require more standards and impose more penalties when current standards and penalties are still not enforced. Clearly, this process can only be half effective in securing effective consumer protection.

[Additional material follows:]

ADDITIONAL MATERIAL

STATEMENT OF CHARLES SISSON

Senator Kennedy, Senator Pell, my name is Charles Sisson and I am the President of Mass Home Care, which represents 30 non-profit Area Agencies on Aging and home care corporations covering every city and town in the Commonwealth of Massachusetts. I am honored to be able to present this statement on behalf of myself, and Al Norman our Executive Director.

This morning as we speak, our agencies are helping to keep 33,000 elders—from Provincetown to Pittsfield—living at home, with dignity and independence. Thousands of these consumers would be in nursing facilities without care at home. We have waited nearly 30 years for a United States President to recognize the preventive role of home care—and we finally have a health care plan that affirms our motto: "There's no care like home care!"

The President's home and community based services block grants represent the first significant federal response to long term care since Medicare and Medicaid were created. We know this plan is a cautious beginning, but we want to encourage lawmakers to consider the following consumer enhancements to the plan;

1) make the long term care eligibility trigger in this plan 2 Activities of Daily Living, not 3. If an elder is able to get out of bed in the morning, put on their pants or skirt, and go to the bathroom without personal assistance, they will not enjoy the benefits of the President's plan. We estimate that nearly 22,000 of our clients (two-thirds) would not pass the "3ADL" test. Yet many of these elderly or disabled people need help to remain at home.

2) don't allow states to use their new federal funds as a offset for state money. We have \$100 million in state funds for home care, and we worry that new federal money will simply be used by the state to reduce the state's commitment to home care.

3) help consumers find the services they need by creating a "one stop shopping" approach to services. One of the hardest things for families to do is find their way through the long term care maze. We ask that you require states to designate a co-ordinated entryway into the long term care system, whether funded out of state money, Medicaid money, or a long term care block grant. Right now, we have a fragmented long term care system: with confusing entryways, duplicative assessments, and frustrating bureaucracy.

Massachusetts long term care is handled by at least 2 separate Secretariats, with separate assessment and intake rules. Whatever else we leave up to states to decide, we should require that their state plan for long term care demonstrate a co-ordinated single entry point system of assessing and careplanning. Isn't it time we stop confusing families?

4) give consumers full choice of services, and a guide who will act as their agent—not as the agent of a provider. Consumers need an independent care manager, who is not owned by a provider agency. This is why the Older Americans Act now separates out the person who assesses what you need, from the person who provides your services. We need similar consumer protections in the Health Security Act, otherwise providers will literally self-serve. Senator Kennedy, your 1989 "Life Care" legislation hit the mark directly: "Any entity performing case management services," your bill said, "shall not be allowed to self-refer for services included in the care plan of such individual." We believe that consumers should have a choice of providers, and should not be assessed by providers. Freedom of choice is not a detail to consumers.

5) give the elderly and disabled the right to an assessment and careplan—not just to those who are eligible for the new LTC plan. We understand that a consumer's entitlement to an assessment and plan of care has been dropped, and that only those screened 3ADL eligible will get assessed. Our experience over the past 20 years has been that consumers given a decent careplan will not make costly mistakes later. Too many families have jumped for institutional care because they thought "that's all Mom is really eligible for". As we add more and more options to the long term care continuum—it makes more sense for us to share that information with families—just as we now have an Older Americans Act mandate to provide information and referral to all consumers—regardless of income or frailty.

6) do not overly-medicalize long term care services by conditioning them on the need for acute care. In the guaranteed benefit plan, home health care benefits are only available "as an alternative to institutionalization", and extended care (nursing home) services only "after an acute illness or injury as an alternative to continued hospitalization." We would never permit this kind of language in a long term care insurance policy—because it severely limits the usefulness of home health and nurs-

ing home services. We don't need this kind of a medical threshold for custodial care, or home health services.

7) give elders some protection for dental, hearing, and vision care. We have never understood why an older persons' ears, eyes and teeth are not covered by Medicare. The President's plan offers a routine eye exam for seniors every other year—if they drop Medicare—but has only planned preventive or restorative dental care, and apparently does not help pay for dentures or hearing aids.

8) use Medicare Part C to create a self-financing way to pay for long term care insurance. We have filed state legislation to reform the provision of private long term care insurance. We have spoken with scores of consumers who have thrown good money after bad and misleading LTC insurance policies. It is not enough to offer a consumer inflation protection—you must mandate it. It is not enough to create tax incentives for LTC insurance—you must also ensure that insurance companies are NOT allowed to cream off only the healthy subscribers. We would much prefer to see Congress give elders a Medicare-endorsed plan, even if they have to pay for it all out of pocket—than simply open them up to long term care insurance agents.

The President's plan is truly a remarkable first step towards health security. Many of us were just children when Medicare was created, but now we worry that we will be elderly by the time a decent long term care program is in place. We want to work with you to make this plan work for consumers. Give this plan a good physical exam, from head to toe—but move boldly to guarantee that the promise of long term care becomes a reality for every elderly and disabled person in this country.

Thank you.

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 36,000 member professional association welcomes the opportunity to submit testimony on the Senate Labor and Human Resources Committee hearing on Long-Term Care: Security for Senior Citizens and the Disabled. Respiratory care is an allied health profession caring for those individuals suffering from diseases and abnormalities of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis, and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and people of all ages who require the use of a ventilator to breathe are all often cared for by the respiratory care professional.

The AARC advocates reform which incorporates the principle of universal, non-discriminatory access to a continuum of comprehensive benefits ranging from preventive to continuing care services. Assured appropriateness and quality of care, improved system efficiency, and equitable cost containment should also be central goals of health reform. While there are many excellent components of the Clinton Administration plan, the area of greatest concern to the respiratory community is the utilization of Medicare coverage as a basis for the benefits package.

Medicare respiratory policies were developed in the late 1960s when most respiratory patients had to be cared for in the hospital setting. That premise is simply not warranted today, and does not reflect the current practice of respiratory care. Many respiratory patients, such as those with chronic emphysema or asthma, cystic fibrosis, or even those ventilator-dependent, do not always need to receive care in the hospital. Respiratory services for these medically-stable patients can be offered at less cost to the health care system in the outpatient setting, the nursing home setting, or in the home.

The Clinton health reform proposal does provide an option for consumers to enroll in a health maintenance organization (HMO). Yet, the proposed Administration's benefits package does not recognize the difference between HMOs and standard indemnity programs. In effect, Medicare is an indemnity program. Its benefits tend to be bundled into the most expensive care setting, the hospital. For example, we know that many respiratory Medicare patients are admitted to hospitals simply because respiratory benefits would not be provided in other, less expensive care settings, such as the home or outpatient facilities. This information is corroborated by a 1990 study performed by the Gallup organization, which shows that up to 30% of ventilator-dependent patients are in the acute care environment because reimbursement or beds are not available outside the hospital. A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. The survey estimates that there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated \$789 per patient per day. This totals over \$9 million a day! Once a patient is medically able to be discharged, it takes an average of 35

days to place a chronic ventilator-dependent patient in an alternate care site such as the home or skilled nursing facility. That translates to an excess of \$27,000 per patient in unnecessary hospital costs. This contributes to the alarming increase in health care costs. By using Medicare as the basis of coverage for all Americans, many more individuals, now covered by private insurance or HMOs, who are receiving respiratory care services on an outpatient, sub-acute, or home care basis, would be required to return to the hospital for treatment of their respiratory problems. They would lose their access to less costly, nonhospital-based respiratory care.

A specific example of the difficulty Medicare patients have in securing nonhospital respiratory care, and what could be faced by thousands of Americans with respiratory disorders, is illustrated by Ms. Lavonne Frizell of Emporia, Kansas. Ms. Frizell has acute bronchietasis, a chronic disease of the lungs, which could be fatal if left untreated. For the

past five years, her condition has warranted respiratory care services. During the majority of this time, Ms. Frizell has been treated on an inpatient basis and outpatient basis. In early 1993, arrangements were made by the local hospital and home care company which permitted Ms. Frizell to remain at home and self-administer her daily respiratory treatments. Her condition became much more stable to the point where she no longer needed to be hospitalized for the intensive respiratory treatments. In fact in the six months since she began her home therapy treatments, she has been an outpatient only one day. Her respiratory illness can be managed by receiving occasional outpatient respiratory services and continuing her home treatments. In spite of this improving situation, Medicare would not cover the outpatient respiratory services or the home care devices and care. Basing their decision on 1960s' Medicare coverage policies still in effect, Medicare ruled that respiratory services and equipment would not be covered in the outpatient or the home setting. It took the intervention of national political leaders in order to amend that policy for Ms. Frizell. Ms. Frizell and her hospital kept excellent records over the last five years, and the following is a break-down of her inpatient vs. her outpatient charges:

Total 1988-1992

Total Inpatient	78 days	\$72,335.38
Total Outpatient	106 days	\$16,967.57
Total		\$89,302.95

Average/Day

Inpatient	\$ 927.38
Outpatient	\$ 160.07

1993 (Medicare Payments-Hospital Only)

May 5, 1993	1 day	\$ 259.15
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It is very apparent that it is less costly to the health care system for Ms. Frizell to receive her care outside of the hospital, rather than as an inpatient. Ms. Frizell's problems and those of many thousands like her are rooted in the outdated Medicare policies for respiratory care services. This would be the same policy the Clinton plan would adopt for the entire country. If Medicare benefits are implemented without change, the problems Ms. Frizell encountered in receiving her respiratory services would also be experienced by other non-Medicare respiratory patients.

The AARC recognizes there is a problem with waste and overutilization of services provided outside the hospital. It is accepted hospital practice for the respiratory care practitioner to evaluate and assess the patient's response to therapy. Based on the patient's condition, the therapist notifies the attending physician of recommended changes in therapy procedures, such as equipment adjustments. This is a role the respiratory care practitioner should be playing in the alternate care site. We are concerned that many health reform proposals are basing cost control on limitations of benefits, rather than limitations on utilization. Health reform proposals are not addressing these root problems, but solving them by limiting the benefits offered to patients. The respiratory care profession has had clinical practice guidelines for some time. These practice parameters are recognized and utilized by the

respiratory care community, and help ensure that only appropriate respiratory care services are rendered.

In the hospital setting, there is evidence that use of therapist-driven protocols, using standardized regimens of treatment that allow the respiratory care professional latitude in monitoring patient response to therapy under physician order, is cost effective. Therapist-driven protocols are being supported by the hospital industry as an effective and efficient use of hospital personnel. The savings resulting from use of protocols in the hospital could be realized in the non-hospital settings as well, so that orders for treatment could change with the patient's condition in a more timely fashion. These kinds of utilization controls, coupled with the fact that every study ever done on home respiratory care services documents cost savings, leads us to strongly encourage the inclusion of respiratory care services in all health care settings. This will certainly lead to a more cost effective method for delivery of respiratory care, but no doubt promotes better quality of life for patients.

On behalf of those thousands of respiratory disabled patients from across the country, we urge the committee to recommend the appropriate access and utilization of respiratory care services as part of the benefits package. Please do not perpetuate the medical coverage of the 1960s and limit the disabled Americans, such as Ms. Frizell, to the most expensive care sites, such as the hospital, in lieu of other cost-effective alternatives.

STATEMENT OF THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

Mr. Chairman, the National Association for the Support of Long Term Care is a broad based alliance of suppliers and providers of professional medical services and products. Over 150 companies are active NASL members. Through our structure of six working coalitions (rehabilitation, wound care, medical product and supplies, portable X-ray, clinical laboratory, and pharmacy services), we are able to provide an assessment of issues which would affect the ancillary and support services offered to patients in nursing facilities.

We appreciate the opportunity to provide testimony on President Clinton's legislation entitled "The Health Security Act of 1993." We applaud the President and Mrs. Clinton's leadership in offering Congress legislative solutions to ensure all Americans have access to affordable health care services. We commend President Clinton's leadership in defining six points for reform: security, simplicity, savings, quality, choice, and responsibility. As an association, we are also committed to these key principles, however, we believe that some areas for reform are not adequately addressed and we offer constructive input in reforming the plan, especially for those services provided in the nursing home setting.

The Changing Setting for Skilled Nursing Care

Over the past decade, nursing facilities have transformed into centers for subacute medical services. Several dynamics have propelled this transformation: higher patient acuity as patients are transferred out of hospitals at a quicker pace; changing care settings which allow patients to receive services in the least restrictive settings based on patient need, quality, and safety considerations; and regulatory mandates as included in OBRA '87 which requires that nursing homes help residents achieve "the highest practicable level of functioning."

Patient needs, mandated changes and market opportunities have placed tremendous demands on facilities to upgrade professional medical services. Nursing facilities have strengthened physician relationships; increased the utilization of specialty medical services and supplies and expanded specialty programs. They have turned to the members of NASL to request an expansion of our support services and programs to meet their residents' needs.

President Clinton's Health Security Act of 1993

We remain concerned about various issues which need to be addressed in greater depth:

- 1) opposition to medicare cuts to finance health care reform; 2) leveling the playing field across all settings; 2) enhancing the long-term care public/private partnership; 3) committing resources only with adequate financing; and 4) the residual Medicaid long-term care funding.

Proposed Medicare Cuts

We oppose using Medicare cuts as a funding basis for health care reform. The proposed \$124 billion in Medicare cost increase reductions will erode the quality of care provided to elderly and disabled citizens, even those in need of long term care. As a nation, we cannot afford to provide lower quality care to the many in order to expand that care to the few.

Leveling the playing field for all providers

While the focus of the legislation is to ensure all Americans have access to adequate health care, NASL believes no provider categories should be excluded from the market place. Rules may be necessary to prevent such exclusions. Patients receive appropriate services in hospitals, nursing homes, assisted living facilities, or at home dependent on the availability of services and acuity of the patients' needs. Health care reform must give providers, suppliers and patients the assurance that no artificial barriers will trap patients in one setting or another. Judgments must be made on the appropriate use of all existing medical services, and we must ensure access to professional services in all settings.

Public/Private Partnership

Long term health care must be a part of any truly comprehensive effort at health care reform. Title II of the President's plan should stimulate meaningful debate. Given limited government resources to finance long term care for every American, we cannot rely on a system that is publicly financed. We support a system that urges Americans with the financial means to plan and pay for long term care as part of a public/private partnership for long term care services. We believe the American Health Care Association's proposal has advanced a positive approach for long term care services: Provide appropriate access to a full continuum of long term care services; Ensure that all Americans have the means to meet the cost of long term care; Move families away from dependence on government welfare programs for long term care financing; and Address the nation's long term care needs in a fiscally responsible way.

The public/private plan should 1) rely on case management for the most appropriate placement for services; 2) strengthen enforcement of Congress' recently passed Budget Reconciliation Act asset transfer provisions and; 3) create value in the long term care private insurance market by setting standards which safeguard purchasers of long term care insurance.

Oppose Artificial Price Caps and Global Budgets

While there is a desire to ensure access to affordable health care, NASL is concerned about the development of unrealistic expectations. By the creation of global caps which set funding limits on health care services, medically necessary services may be rationed. When people are in most need of care, they may find themselves out of money and exceeding some artificial government cap. We oppose capping the health care system and urge Congress to avoid such price controls that only stifle innovation and erode the quality of health care services.

NASL believes that important alternatives are necessary to controlling costs. First, we must develop a continuum of care management which ensures that patients receive appropriate services in appropriate settings. Merely setting artificial time-frames or dollar amounts for care ensures rationing. Second, we believe that health care professionals must be allowed to provide services they are trained and licensed to provide. Finally, we believe costs can be reduced by ensuring patients complete their rehabilitation to improve their functional capacity and prevent further deterioration. We are most concerned that without adequate reimbursement for supporting ancillary services and appropriate follow through, the system will become more, not less, expensive.

Adequate State Financing

As President Clinton's plan creates a new capped entitlement for home and community based services, NASL is very concerned about the impact of this program on States' ability to adequately finance long-term care services under Medicaid. As there will be driving forces to finance both institutional and home based services, quality in both may be eroded.

Again, we believe that patients needing long term care should get services where the care may be most appropriately provided. That will, in some instances, be institutional, in others home based. We believe that there should not be categorical exclusion based on place of service and believe that the creation of new entitlements for services at home may create unrealistic expectations or unanticipated expense. A phenomenon known as "the woodwork effect" will likely develop. In the woodwork effect, informal caregiving (currently unreimbursed as health care) erodes as people become eligible for paid home care. Availability of such care will automatically increase demand. Such demand for services in light of existing state budget constraints will likely force States to either increase taxes to pay for the additional demand or reduce provider payments, thereby reducing the quality of services. We urge you to proceed cautiously in a fiscally sound way to ensure that we strengthen,

not erode, an important public/private partnership in providing long term care benefits to Americans.

Conclusion

The key to ensuring Americans' access to quality services is to encourage competition on fair terms with adequate reimbursement. We fear reforms may not let smaller providers compete on the basis of access and quality. We urge you to consider that if reforms are not carefully thought through, there may be a bias against the small provider who serves patients in nursing homes, in rural areas, and in places where large, national providers rarely serve.

We are ready to work with members of Congress in developing meaningful reforms. We offer our expertise in defining the role of the ancillary provider in the evolving program for providing health care services. We remain eager to provide additional input on the reform plan and you may look forward to our continued communication and cooperation.

[Whereupon, at 12:55 p.m., the committee was adjourned.]

MEETING MATERNAL AND CHILD HEALTH NEEDS UNDER THE HEALTH SECURITY ACT

TUESDAY, NOVEMBER 16, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:20 a.m., in room SD-430, Dirksen Senate Office Building, Senator Dodd presiding.

Present: Senators Dodd, Simon, Wellstone, Kassebaum, and Jeffords.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order.

I thought we were going to vote at 10 o'clock, right on the button but the vote has been delayed a while now. And Senator Kennedy is managing the Freedom of Access to Clinic Entrances Act, which is presently ongoing.

I have been joined by my colleagues. Good morning. It is good to see you.

Let me begin with some opening comments about this hearing this morning and then go to my colleagues, and we will proceed as quickly as we can before another vote comes up.

First, I would like to welcome everyone here this morning to the Committee on Labor and Human Resources for our hearing on the health care needs of children and pregnant women.

The current session of Congress began with good news for families and children when we passed the Family and Medical Leave Act, after 7 years of battling. President Clinton in fact signed it into law as his first piece of legislation. I hope that when this Congress come to an end, we will have more good news for families, for children, and for pregnant women when we pass the comprehensive health care reform legislation, and that that legislation will meet the needs of all Americans, including children and pregnant women.

As I think this hearing will show, children and pregnant women often have the greatest need for good health care, yet far too many have no access to it. We can no longer tolerate this situation, and I would suggest that the following standard be applied to each of the health care reform proposals now on the table. Will it guarantee every one of our Nation's children and pregnant women access to necessary health care?

If the answer is no to that basic question, that it will not guarantee health care to these groups, then frankly, I think that the plan

is unacceptable, no matter how attractive its other features may be. The American Academy of Pediatrics will provide us this morning with valuable information and point out that no matter how attractive those plans may be, if they do not deal with children and pregnant women, then that plan is just not workable.

Earlier this year, I worked with the Academy to develop and introduce legislation that highlights issues that need to be addressed when talking about children's health, and I hope that it provides a useful basis for discussion as we move forward with comprehensive health care reform.

One thing we already know is that our present system is not meeting those needs. A handful of compelling statistics clearly demonstrate this fact. As we sit here this morning, talking about the health needs of children, approximately 12 million Americans age 21 and younger do not have the protection of health insurance. And despite what many people may think, this is not a problem that affects only poor Americans. Sixty-five percent of families with uninsured children have income above the Federal poverty level.

We know, too, that adolescents in particular face many challenges in today's society—violence, teen pregnancy, sexually transmitted diseases, and substance abuse too often are part of their day-to-day experiences.

Adolescents face these challenges, which clearly affect their health, yet 4.6 million adolescents lacked any insurance in 1989. That is 15 percent, or one in seven, of all adolescents in this country.

These statistics are compelling, yet we must always remember that when we talk about health care reform, we are talking about much more than a pie chart or a regression analysis. We are talking about real people with real needs, and too many of those needs are not being met.

Child immunizations are a case in point. One in four American preschool children lack complete immunization against serious diseases like measles, whooping cough, mumps, and polio. The rates in many inner cities are as low as 10 percent.

Like many of the failings of our system, this one ends up costing us a great deal more money in the long run. According to the Institute of Medicine, every dollar spent on immunizing children will save \$10 in long-term health care costs.

The same is true for prenatal care. Studies have shown that every dollar spent on this kind of care saves \$3.38 in medical care for low birth weight babies. Many of these babies will have health problems that will last their entire lives.

This issue was highlighted recently by a report on the problem of boarder babies. These are children, many of whom are born to women with substance abuse problems who are left in maternity wards of hospitals all across this country. There were an estimated 22,000 such babies in the Nation's hospitals in 1991.

We will hear this morning from an array of patients, families, and providers who can speak first-hand about the experience and needs of children and pregnant women in the health care system. These are individuals who both know and have been affected in very real ways by our health care system.

I expect that we will hear today about concrete ways that health care reform can be shaped to meet these needs. I hope we will be especially attentive to their words and not let them get lost in the whirlwind of statistics and analysis that can overwhelm gatherings such as this one.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today's hearing considers a major aspect of President Clinton's Health Care Plan—its impact on children.

The pledge of comprehensive health care for all Americans in President Clinton's plan is of special importance for them.

Currently, nine million children have no health insurance. In addition, a recent study predicts that one-fourth of all children—16 million—will lack health insurance at some point during 1993.

The erratic, minimal care these children receive is inadequate to protect them against many preventable conditions. The result is massive unnecessary illness and suffering, and excessive costs for the health care system when care is finally provided, often under emergency conditions.

President Clinton's plan will guarantee health coverage and access to health services for all children. Many health problems suffered by children are avoidable. Immunizations, for example, are highly cost effective. Routine examinations and preventative care save lives and mean healthier and happier children.

Through its Standard Benefits Package and new public health initiatives, the President's plan will provide comprehensive coverage and provide for greater access to health care for all children.

School based clinics and other forms of community based care will enable doctors and nurses to bring care to those who need it, in the places where they will use it.

The plan means new access to prenatal care. It will provide health education and training so that pregnant women are better prepared to care for themselves and their children. It moves us closer to the goal of guaranteeing accessible prenatal care to all women for the first time in our history.

Children are not "mini-adults." They require services especially suited to their developmental needs as infants, young children, and adolescents.

We must provide a delivery system that responds to these needs. Insurance alone does not mean children will actually receive care. A key part of health reform is assessing their health needs and seeing that they are met.

I look forward to the testimony of this distinguished panel of witnesses.

We will hear the perspectives of parents who know firsthand the challenge of obtaining adequate health care for their children, and from providers who struggle hard to provide it. The nation is on the threshold of a major breakthrough in meeting the health needs of children, and it is an opportunity we cannot afford to miss.

Senator DODD. I want to welcome all of our witnesses this morning and thank them for taking the time to join us. We look forward to hearing their ideas and suggestions.

Let me turn to our colleague from Kansas, Senator Kassebaum, and then Senator Wellstone.

Senator KASSEBAUM. Thank you, Mr. Chairman. I have no opening statement.

Senator DODD. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman. I think it would be better just to go right to the panelists.

Senator DODD. Fine. Let me thank everyone again for being with us.

Dr. Brazelton is our lead-off witness this morning. It is only fitting that this committee turn to you, Doctor, for advice on meeting maternal and child health needs, just as parents around the world have turned to you for advice in caring for their children.

Dr. Brazelton's book, "Infants and Mothers," has been translated into 18 languages, and his neonatal behavioral assessment scale is used worldwide to assess not only the physical and neurological responses of newborns, but also the emotional well-being of babies at birth.

Dr. Brazelton can tell us why it is so important that children be guaranteed health care coverage.

Our next witnesses will focus on real stories about how the current system has met or failed to meet maternal and child health care needs.

I want to thank Lynn Morrison of Stone Mountain, GA for joining us this morning to share her personal story about the current health care system and the impact it had on her second pregnancy. She will describe her problems in obtaining prenatal care, which we all know is critical to getting kids off to a healthy start.

Eva Skubel, my neighbor and friend, from Moodus, CT, is not a stranger to this committee. The same problems she will describe today brought her to Washington at the beginning of this year to testify for family and medical leave. Eva joins us this morning to describe the problems of the current health care system has imposed on her family because her daughter Jacinta has several health care needs, which she will describe.

I might point out that Eva is now also deeply involved with more than just her own family, at the Family Center at the Newington Children's Hospital, which she runs. The Center helps families that have children who suffer from severe physical problems. She now deals with these issues on a daily basis, so she has taken her experience and turned them into something very positive for all of us in Connecticut.

Eva, I am pleased that you are here this morning.

Joseph Medlin is from Far Rockaway, NY, where he is a captain on the Far Rockaway basketball team. He will share with the committee this morning his view on Far Rockaway's school-based clinic. We often hear about the health of youth from adults, and I thank Mr. Medlin for joining us this morning to share with us first-hand his views. We thank you for coming down.

Dr. Brazelton, it is a pleasure to have you. It seems a little strange not to see you with a child this morning—but you are close. I see you are reaching out already.

Thank you for coming. We look forward to your testimony.

STATEMENTS OF DR. T. BERRY BRAZELTON, PROFESSOR OF PEDIATRICS, HARVARD MEDICAL SCHOOL, BOSTON, MA; LYNN MORRISON, STONE MOUNTAIN, GA; EVA SKUBEL, MOODUS, CT; AND JOE MEDLIN, FAR ROCKAWAY, NY, ACCOMPANIED BY DR. MARTIN FISHER, CLINIC DIRECTOR

Dr. BRAZELTON. It is fun to be here with you all. I wonder where the rest of them are, though?

Senator DODD. They are coming.

Dr. BRAZELTON. They should be hearing this.

Senator DODD. I should tell you that Chairman Kennedy is chairing the action on the floor this morning so really could not be here, but he will try to come if he can.

Dr. BRAZELTON. The last time I came down here, I had to bang on the table to wake people up. I hope that will not happen today.

Senator DODD. I doubt that.

Dr. BRAZELTON. Chris, one thing I wish you had mentioned in your announcement of what this is all about is prevention, because to me, the most important thing about this bill is that it brings prevention into the fore, and from a pediatrician's standpoint, that is absolutely critical.

Our present medical system is not working. In fact, from my standpoint, it stinks. Infant mortality is so high that we, as one of the richest nations in the world, stand 21st in the world. And this statistic implies that we are not reaching vulnerable women in their pregnancies, because infant mortality is directly corrected with inadequate prenatal care. We know this, and we have good examples of this all over Europe.

France, for instance, now pays a pregnant woman \$1,000 for four prenatal visits, and they have reduced their infant mortality from one of the middle in the world to one of the lowest in the world in 2 years. This seems like an obvious way for us to go. If we can pay, or at least encourage pregnant women to come in, we could cut down on infant mortality.

But mortality is only the tip of an iceberg. Morbidity in children, which goes along with mortality, but does not cut itself off, costs society a lot more in financial investment, in time, and in personal suffering.

High-risk pregnancies could be identified and handled without the terrible cost of prematurity and of intrauterine growth retardation. One high-risk infant costs society an average—and I am just guessing at this—of \$75,000 to \$100,000 for prenatal care. That would mean at least 100 women that we could pay for prevention.

The outcome of these fragile infants can cost our social services, our schools, our institutions an incalculable amount. If we were offering respectful—and this is a key word—respectful, nurturing preventive care to women at risk, we could reach out to them in pregnancy and in their children's infancy to offer the rehabilitative services they sorely need.

When Mrs. Clinton was constructing this bill, I got a chance to go down and talk to her about some ideas I have about how to reach out for women who have been disillusioned by our medical system, who are frightened of it, who think it has nothing to offer them, and they are pretty right. But we do know how to reach out for people from other ethnicities, from other socioeconomic classes

now, and if we do not start doing it, we are going to pay a terrible, terrible price at the other end.

We need to provide for universal coverage of these preventive services, and we need to think about how we are going to do them this time—not with a deficit model, which we have had so far, which just lists people's failures, but how are you managing? How are you getting there? Can we help with this proposed health care bill?

This health care bill, as far as I know, would do that.

Our new morbidity in this country, in pediatrics, at least, is in epidemic form. It is poverty, violence, HIV, drug-addicted infants. We do not have any idea of the epidemic that we are into. Eighteen percent of babies born at the Boston City Hospital are born to addicted women, and they are very disordered infants. Twenty-five percent in the Chicago inner city hospitals, 25 percent in New York and Washington, and probably 38 percent in Miami.

Senator DODD. And that is overall, by the way. If you go to specific hospitals, I would expect that the numbers get much higher.

Dr. BRAZELTON. These are inner city hospitals, so they are not actually overall. But they are the most frightening, because your children, and my grandchildren are going to have to face those kids on the street in the future, and we have a pretty good idea now from research as to how these kids will turn out if they are not provided with appropriate environments.

We need to invest in front-ended early intervention for fragile and at-risk infants. There is an enormous waste in neglecting something which we have come on recently, that there is tremendous plasticity in the nervous system in immature infants. There are redundant pathways that could be captured to be put to use, even if you have got a knocked out system.

If I hold a normal baby up here, with its head here and its bottom here, and talk to it—"Hi, come on, you can turn to my voice; come on, you can turn to me"—a normal infant will turn, look you in the face, and then when it looks you in the face, it brightens, like, "Hey, there you are."

If I put the mother over here, and we both talk, any newborn will turn to its mother's voice, and she automatically grabs her baby and says, "You know me already." So they are off to a good start.

Now, you take a fragile or at-risk baby and do the same thing—"Hi, come on, turn to me"—that baby will arch, frown, turn away, spit up, have a BM, turn blue around the mouth, telling the mother, "I cannot take you."

Now, what does that mean to the mother of a fragile infant when she is starting out? It means that they are automatically set up for rejecting that interaction, and we are losing the opportunity to reach out and bring these people back into communication with each other.

On the other hand, if you take, say, a fragile infant—a blind infant, for instance—a blind infant has hypersensitive auditory, tactile, and aesthetic systems, because once you knock out one system, the others automatically become hypersensitive to try to take over. So if you talk to a blind infant like I just did, he will turn away. But on the other hand, if you talk to him like this—"Hi, come on, you can turn to me; come on, you can do it"—a blind infant will

stop moving, its face will knit, it will turn to your voice, scan for where your radar is coming from, and will brighten.

I had a mother the other day who was a lawyer, and her husband is a judge, and she said, "My God, it is a baby."

So this is the kind of thing we could do with universal health coverage. And if we do not get to work, we know that the immature central nervous system will not recover in an appropriate way. If we do provide environmental input to these disordered nervous systems, we could probably salvage 85 percent of these addicted babies, and that means that we could save maybe the mothers, too, but certainly the babies.

We have learned a lot about fragile and at-risk babies since the passage of Bill 99-457, which was a real breakthrough, and we can provide services which will delay the rapidly increasing population of learning disabled and attention-disordered, ADHD children, from maternal addiction. These children are going to rapidly overload our educational systems and our penal institutions if we do not intervene early. If we do, we could salvage, as I said, 85 percent of them.

The new health care bill could provide early identification services using EPSDT if we had the capacity to pay and to cover the early intervention services that we know how to do. I am not talking about something we have to learn about or research. We have already done that. The new health care bill provides for early identification and remedial services for all at-risk infants.

We could pay for all of the proposed medical care revisions by front-ending these services, to offer these children a chance to function successfully in our society, rather than becoming the burden we know to expect from them without intervention.

Meanwhile, we are not reaching high-risk, needy families. This is how the present health system is failing. Twenty-four percent of children are below the poverty line, and they must resort to unwelcome AFDC to cover. Not only are they on AFDC, and their medical costs are not covered satisfactorily, and hence they are being refused by the medical system, but they and we hate the labels.

What David Elwood says is that welfare is like cancer in our society. And I say we are treating them like dumb rats, if you know about that research at Harvard. Bob Rosenthal randomized a bunch of rats and put them in two cages, and he labelled one "smart rats" and the other "dumb rats." And he got his graduate students to put them through a maze. None of the "dumb rats" got through, but all of the "smart rats" did. What his graduate students did was pick up a smart, middle class rat, put him down, and he would run right through. Then, they would pick up a dumb, lower class rat, drop him in, and he could not stagger through.

They filmed his graduate students, so we have that on film now, and this is exactly what happens to people who come in with AFDC. They get treated like a "dumb rat." Now, I think people live up to those labels.

If, on the other hand, when they walked in the door, someone said to them, "What a beautiful baby that is. Look how she is chewing on her fingers, and look how she looks up in your eyes when you look down at her. Isn't that wonderful? Aren't you having

a great time with that baby?"—no mother would ever miss another visit.

So we are missing the point about how to get in. We are now 19th in the world in the deaths of children. This is a new UNICEF compilation of where we stand in the world on some of these things. We are 19th in the death of children. This is absurd. And if you added on murders, we would be way down.

So insurance companies are the only ones who are having any fun. They are demanding more and more paperwork, and the costs of medical insurance are rising. No one has access to preventive care who cannot pay for it themselves. Forty percent of children have no health coverage under this present system at all—insurance does not cover them. Children's health needs are not covered by current employer-based health plans. Less than 50 percent are covering immunizations or well-child care, and only 24 percent cover eye care.

Now, what are we saying by this kind of statement? Fortunately, States are beginning to step into this. Governor Casey the other day pushed a bill through in Pennsylvania that ought to be a representation for the whole Nation. Hawaii is on its way. Texas, I hear from my friend, is beginning to think about it. Many States are beginning to think about it, but they need the backup of a national mandate. They cannot do it alone.

Doctors are certainly not happy with our present system. The insurance companies and the lawyers are running our business and are running up costs with unnecessary technology which no one wants. We do not want it. Patients do not want it. But we are all afraid of malpractice, so we order backup tests which neither patients nor we feel are clinically necessary. We need to place a cap on malpractice suits and to cap lawyers' fees, which are out of control in these suits.

While most children are basically healthy, health care costs for the 5 percent who are sick account for 59 percent of our health care expenditures; 27 times greater than the mean expenditures for 95 percent of all children.

We need to intervene early in these children's diseases in order to prevent these costs. We can do that. We know how to do it. In managed health care plans, a multidisciplinary approach could provide nurse practitioners or psychologists in every plan, whose attention to the child's development and the parents' anxieties could be met in the way that I was just saying. If you had somebody in that office, just talking about the baby and his development, parents would flock into that office, from every sector of our society. And if we could talk in the ethnic language, in the belief systems of people who are not being reached today, we could reach them.

We have a new program at Harvard in which we are trying this out, and we have increased compliance in our inner city from 38 percent to 94 percent in terms of return visits, in terms of breast feeding. It can be done, and we know how to do it.

We could construct a preventive program in multidisciplinary, managed care plans, which could serve all parents, with enough support and information to prevent an increasingly large percent of their health and emotional problems. But we need universal cov-

erage and a health care plan which will pay for preventive services. Those two ought to be the key words.

It is time we changed our ineffective medical system to one which can reach out to all members of our society, especially vulnerable new families and their children. Every other civilized Nation in the world has realized this and has instituted such a system. Why are we so long in realizing this? I do not understand it.

Thank you.

Senator DODD. Thank you, Doctor, very much.

[The prepared statement of Dr. Brazelton follows:]

PREPARED STATEMENT OF DR. T. BERRY BRAZELTON

The present medical system is not working. Infant mortality is so high that we, as one of the richest nations, stand 21st in the world. This statistic implies that we are not reaching vulnerable women in their pregnancy. Infant mortality is directly correlated with inadequate prenatal care. We know this because countries like France, which pay a pregnant woman \$1,000 for four prenatal visits, have reduced their infant mortality to one of the lowest in the world and within a few years of the institution of such a program.

Mortality is only the tip of an iceberg. Morbidity in children costs society much more—in financial investment, in time, and in personal suffering. High-risk pregnancies could be identified and handled without the terrible cost of prematurity and of intrauterine growth retardation. One high-risk infant costs society an average of \$75,000-\$100,000 for perinatal care. The outcome for these fragile infants can cost our social services, our schools, our institutions an incalculable amount. If we were offering respectful, nurturing preventive care to women at risk, we could reach out to them in pregnancy and in their children's infancy to offer the rehabilitative services they sorely need. We do know how to do this. But we need to provide for universal coverage of these preventive services. The proposed health care bill would do that.

We need to invest in front-ended early intervention for fragile and at-risk infants. There is an enormous waste in neglecting the plasticity of impaired infants in the first few years. We do know now that the immature central nervous system can recover from insults—intrauterine or perinatal insults—if we can provide environmental input to those disordered nervous systems, all too often fragile and hypersensitive. But we know how to do that, too. We have learned a great deal about at-risk infants and their families since the passage of Bill #99-457. We can provide services which would allay the rapidly increasing population of learning disabled and attentionally disordered ADHD children from maternal addiction. These children will rapidly overload our educational systems and our penal institutions if we don't intervene early to assist them in their withdrawal and their reorganization after the intrauterine insults of alcohol and drugs. But we do know how to do that. We estimate that we could salvage 85 percent of these disordered infants and children by appropriate identification and outreach with early intervention services. The new health care bill could provide the early identification services (cf. to EPSDT) if we had the capacity to pay for early intervention services. The new health care bill provides for early identificational and remedial services for all at-risk infants. We could pay for all of the proposed medical care revisions by "front-ending" these services to offer these children a chance to function successfully in our society, rather than becoming the burden we know to expect from them without intervention.

Meanwhile, we are not reaching high-risk, needy people. Twenty-four percent of children are below the poverty line and must resort to unwelcome AFDC to cover. Not only are they on AFDC and their medical costs are not covered satisfactorily, but they and we hate the labels. They use emergency rooms in hospitals for their primary care, at ten times the cost. Doctors refuse to accept AFDC patients. They are lost to preventive health care.

Insurance companies are demanding more and more paperwork, and the costs of medical insurance are rising. No one has access to preventive care who cannot pay for it themselves. Forty percent of children have no health coverage at all. Insurance does not cover. Children's health needs are not covered by current employer-based health plans; only 47 percent of conventional insurance plans cover child immunizations; 48 percent cover well-baby care; 39 percent cover well-child care; and only 24 percent cover eye care.

In managed health care plans, a multidisciplinary approach could provide nurse practitioners or a psychologist whose attention to the child's development and the parents' anxieties could be met, while the physician served as a backup for handling the medical needs. We could construct a preventive program in multidisciplinary managed care plans which could serve all parents with enough support and information to prevent an increasingly large percent of their health and emotional problems. But we need universal coverage and a health care plan which will pay for preventive services.

Doctors aren't happy with our present system. The insurance companies and lawyers are running our business and are running up costs with unnecessary technology which no one wants. But we are afraid of malpractice suits, so we order backup tests which neither patients nor we feel are clinically necessary. We need to place a cap on malpractice suits and to cap lawyers' fees which are out of control in these suits.

Physicians and nurses could work together in teams, effectively reaching out to families of children in this preventive system. The proposed health care system could save enough in preventing disorders to pay for the proposed increases which will be necessary to cover every child and every family.

While most children are basically healthy, health care costs for the five percent who are very sick accounts for 59 percent of health care expenditures, 27 times greater than mean expenditures for the 95 percent of all children. We need to intervene early in these children's diseases in order to prevent these costs.

It is time we changed our ineffective medical system to one which can reach out to all members of our society—especially vulnerable new families and their children. Every other civilized nation has realized this and has instituted such a system. Why are we so long in realizing this?

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Senator DODD. Lynn Morrison, we are pleased that you are here.

Ms. MORRISON. Thank you.

Senator DODD. Dr. Brazelton would be glad to hold your baby for you. [Laughter.]

Dr. BRAZELTON. I will take her right now.

Senator DODD. You looked empty-handed; now you look better, Doctor.

Ms. MORRISON. My name is Lynn Morrison. I am here today with my daughter Rachel, who is 7, and my new baby, Deseree, who was born October 1st. My husband was unable to come because he has a temporary night job right now and could not travel with us.

I also would like to thank the March of Dimes Birth Defects Foundation for their assistance in making this trip possible for me.

I want you to know that I am an average working person. I have worked since I was 14 years old. But when I was pregnant with Deseree and needed help getting health insurance, I could not get it. I am here today to tell my story so that maybe other women will not have to go through what I did; others will not have to be afraid that they cannot get in to see a doctor before they deliver; others will not get late prenatal care, like I did, and risk having a problem.

This year, money was a little tight, even though we both were working. We had just bought our first home and had a monthly mortgage payment. My husband and I had not planned this pregnancy. This was not the best time to have a baby, but my husband and I were still delighted to bring a new baby into the world, to care for her, and to give Rachel a new sister.

When I learned I was pregnant, I had just changed jobs to be closer to Rachel's kindergarten and our new home. I left my job at a pediatrician's office because it was a one and a half hour community, and I had difficulty getting Rachel to and from school.

I like my new job, but they do not offer their employees health insurance. At first, I was not really worried, because Rachel is school-age now and pretty health, and so am I.

When I learned that I was pregnant, I tried to get on my husband's health insurance plan through his work. We learned that they had been taking out monthly payments from his paycheck as if he had a family plan, but I was never really enrolled. When he tried to enroll me with the health insurance company after I was pregnant, I was denied because my pregnant was considered a pre-existing condition.

I really wanted this baby to have a good start. I was a little nervous because I am 32 years old, and I was having some discharge. I tried to apply for Medicaid. I went to the welfare office and got a temporary Medicaid card. Then I called several doctors, but no one would see me.

Then I called the Powerline, a hotline in Georgia available free-of-charge to women and children who need help getting health care. The Powerline got its original funding from the March of Dimes, and is now funded by the State of Georgia. Staff at the hotline gave me the names of several doctors who were supposed to accept Medicaid. I called those doctors, but they had long waiting lists; some were booked 3 and 4 weeks in advance. Another office I called told me their computer was down, and they could not make any appointments at that time.

Soon after that, the welfare office told me my income and my husband's income combined was too high to be Medicaid-eligible. So I tried to find a doctor who would see me without insurance. I found one clinic that would see me, but they wanted \$250 to \$350 just for the first office visit. We just did not have that. We were very stressed about it. My husband felt very terrible that he could not take care of our health care needs. I was exhausted from the whole ordeal.

About this time, I was changing from sad and scared for my baby to mad. No one would see me. I thought, I have worked all my life, and for what? No one will insure you if you need it—not even if you are pregnant. I have been putting money into the system for 18 years, and isn't it ironic that I cannot get any health care, when people who have never worked in their lives get Government help?

My baby has the right to medical care. I do not understand why I could not get it just because I changed jobs and we did not meet certain criteria. Excuse me. [Pause.]

Senator DODD. That is all right. You are doing fine, Lynn.

Ms. MORRISON. OK. Sorry. I took the initiative and got on the phone and called around to fine help. No one would help me.

After my first trimester was over, I called the Powerline. [Pause.] I am sorry.

Senator DODD. You are doing fine, Lynn. I know it is not easy, but you are doing really well.

Ms. MORRISON. OK. A very nice woman there gave me the name of a hospital that had a package prenatal plan for uninsured

women. I called this hospital all day long and kept calling, day after day. No one called me back, until finally, I reached someone. I had to fill out an application and wait. In my 5th month of pregnancy, they approved the application, and I got to see a doctor, finally.

They charged me \$3,000 for prenatal care and my hospital delivery and newborn costs. I knew it would be hard for us to pay for this, but maybe we could trim our spending on other necessities enough to make it through the pregnancy and keep up our mortgage payments. We worked out a payment schedule that we could afford, paying half of the amount before I had the baby and half afterward.

Before I had the baby, I went into premature labor twice and was hospitalized. I felt scared, but with the help of the wonderful doctors and nurses at the hospital, I was able to carry Deseree full term. She was born a healthy 7 pounds, 11 ounces.

We are very lucky our baby does not have any problems. Everybody should be able to get health care if they need it. All of this not only put my baby at risk, but we were afraid of losing our house and our marriage. I am here today, with the help of the March of Dimes, to urge you to change the health system so that no other women, children and families will have to go through the ordeals and financial stresses we went through to have a baby.

Senator DODD. Thank you, Lynn, very, very much. It is not easy; it took a lot of courage to come here today. As I have often said here before, we cannot invite everybody who has gone through what you have gone through to come here and testify, so you represent a lot of people.

Ms. MORRISON. I know, and I have met a lot of people since the pregnancy.

Senator DODD. And you did a very fine job representing them here; I want you to know that.

Ms. MORRISON. Thank you.

Senator DODD. And Dr. Brazelton looks like he may walk off with that child.

Dr. BRAZELTON. No; I am about to give her up.

Ms. MORRISON. Because there is no guaranteed health care coverage today, I could not get prenatal care until the 5th month of pregnancy. This could have turned out differently. Only because we used our house as collateral could we pay for this special package offered by the hospital.

Many women in my situation would not be that lucky. Without the hotline, I would not have known what to do. These types of health outreach programs are important to families. You should protect them so women like me know about the health care providers that are available. I hope you hear my story and understand that every American must have guaranteed health care coverage, whether they change jobs, move, get sick, or have a baby.

My husband is studying for a C.P.A. We want a better future for our children. Just last week, my husband was laid off from his job in sales. Now we do not even have insurance at all. I am going to apply for Medicaid, and am hopeful that Medicaid will help us until my husband can get a job that provides health insurance.

I am going back to work next week, after my unpaid maternity leave ends. I need and like my job, but there is still no insurance plan there. We are very happy about having our new baby, but you know, the coming months will not be easy for us.

I hope that you will change the law soon so we do not have to live in fear that someone will get sick in our family or that some important well-baby checkups and immunizations get missed because we are afraid to lose the roof over our heads.

Thank you, Senators, for this opportunity to tell my story.

Senator DODD. Thank you. Well-done.

Ms. MORRISON. Thank you.

[The prepared statement of Ms. Morrison follows:]

PREPARED STATEMENT OF LYNN MORRISON

My name is Lynn Morrison. I am here today with my daughter Rachel, who is seven years old and my new baby girl, born on October 1st, Deseree. My husband, is not able to be with us today because he has a temporary night job and couldn't travel with us. I also would like to thank the March of Dimes Birth Defects Foundation for their assistance in making this trip possible for me.

I want you to know that I am an average working person. I've worked since I was 14 years old. But when I was pregnant with Deseree and needed help getting health insurance I couldn't get it. I am here today to tell my story so that maybe other women won't have to go through what I did, others won't have to be afraid that they can't get in to see a doctor before they deliver, others won't get late prenatal care like I did and risk having a problem.

This year, money was a little tight, even though we both were working. We had just bought our first home and had a monthly mortgage to pay. My husband and I had not planned this pregnancy. This was not the best time to have a baby, but my husband and I were still delighted to bring a new baby into the world, to care for her, and to give Rachel a new sister.

When I learned I was pregnant I had just changed jobs to be closer to Rachel's kindergarten and our new home. I left my job at a pediatrician's office because it was a one and a half hour commute and I had difficulty getting Rachel to and from school. I like my new job, but they do not offer their employees health insurance. At first I wasn't really worried because Rachel is school age now and pretty healthy. I was feeling fine and healthy too.

When I learned that I was pregnant, I tried to get on my husband's health insurance plan through his work. We learned that they had been taking out monthly payments from his paycheck as if he had a family plan, but I was never really enrolled. When he tried to enroll me with the health insurance company after I was pregnant, I was denied because my pregnancy was considered a "preexisting condition".

I really wanted this baby to have a good start. I was a little nervous because I was 32 years old and was having some discharge. I tried to apply for Medicaid. I went to the welfare office and got a temporary Medicaid card. Then I called several doctors but no one would see me.

Then I called the Powerline, a hotline in Georgia available free of charge to women and children who need help getting health care. The Powerline got its original funding from the March of Dimes and is now funded by the state of Georgia. Staff at the hotline gave me the names of several doctors who were supposed to accept Medicaid. I called those doctors but they had long waiting lists—one was booked for three weeks, another told me their computer was down and they couldn't make appointments at this time.

Soon after that the welfare office told me my income and my husband's income combined was too high to be Medicaid eligible. So I tried to find a doctor who would see me without insurance. I found one clinic who would see me but they wanted \$250-\$350 just for the first visit and hundreds of dollars for the blood tests. We just didn't have it. I was very scared. I was gaining weight fast and having some discharge. We were very stressed, and my husband felt terrible that he couldn't take care of my health needs. I was exhausted from the whole ordeal.

About this time I was changing from sad and scared for my baby to MAD. No one would see me. I thought, I've worked all my life and for what, no one will insure you if you need it—not even if you're pregnant! I have been putting money into the system for 18 years and isn't it ironic that I can't get any health care when people who have not worked all there lives can get government help.

My baby has the right to medical care. I don't understand why I couldn't get it just because I changed jobs and we didn't meet certain criteria. I took the initiative and got on the phone and called around to find help. No one would help me.

After my first trimester was over, I called the Powerline hotline again. A very nice woman there gave me the name of a hospital that has a package prenatal plan for uninsured women. I called this hospital all day long and kept calling day after day. No one called me back until finally I reached someone. I had to fill out an application and wait. In my fifth month of pregnancy they approved my application and I got to see a doctor, finally.

They charged me \$3000 for prenatal care and my hospital delivery and newborn costs. I knew it would be hard for us to pay for this, but maybe we could trim our spending on other necessities enough to make it through the pregnancy and keep up on our mortgage payments. We worked out a payment schedule that we could afford, paying half of the amount before I had the baby and half afterward.

Before I had the baby, I went into premature labor twice and was hospitalized. I felt scared, but with the help of the wonderful doctors and nurses at the hospital I was able to carry Deseree to term. She was born a healthy 7 pounds and 11 ounces.

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Because there is no guaranteed health care coverage today, I couldn't get prenatal care until the fifth month of pregnancy. Things could have turned out differently. Only because we used our house as collateral could we pay for this special package offered at the hospital.

Many women in my situation wouldn't be that lucky. Without the hotline I wouldn't have known what to do. These kind of health outreach programs are important to families. You should protect them so women like me know about the health care providers that are available. I hope you hear my story and understand that every American must have guaranteed health care coverage, whether they change jobs, move, get sick, or have a baby.

My husband is studying for a C.P.A. We want a better future for our children. Just last week, my husband was laid off from his job in sales. Now we don't even have insurance for the baby. I am going to apply for Medicaid and am hopeful that Medicaid will help us until my husband can get a job that provides health insurance. I'm going back to work next week, after my unpaid maternity leave ends. I need and like my job, but there is still no insurance plan there. We are very happy about having a new baby. But you know, the coming months won't be an easy time for us. I hope that you will change the laws soon so we do not have to live in fear that someone will get sick in our family or that some important well baby check-ups and immunizations get missed because we're afraid to lose the roof over our head.

Thank you Senators for this opportunity to tell my story.

Senator DODD. Eva, thank you for coming this morning.

I should point out to my colleagues, Eva's child Jacinta was born on my birthday.

Ms. SKUBEL. Thank you, Senator Dodd, and good morning, distinguished members of the Labor and Human Resources Committee.

My name is Eva Skubel. I am a resident of Moodus, CT. I am the coordinator of the Health Financing Advocacy Project in the Family Center at Newington Children's Hospital, a facility that has an outstanding reputation for serving children for almost 100 years.

I am also a Connecticut coordinator for Family Voices, a national coalition that represents children with special health care needs in the discussions on health care reform.

I am the mother of 3 children, one of whom was born with serious and complex health care needs, even though I received excellent prenatal care. These needs began my personal journey of expe-

periences in the present health care system and its failures to families like mine.

My oldest child, Jacinta, was born with a rare brain disease. The nature of her illness requires that she be under the direct supervision of a full 12 hours of nursing care. Essentially, I have in my home a mini-hospital, with oxygen tanks, a C-Pap machine, blood oxygen monitor, suction and feeding pumps. These pieces of durable medical equipment and the presence of nurses in my home are absolutely necessary in keeping Jacinta out of the hospital and alive.

Highly skilled and dedicated health professionals have assisted my family's understanding of Jacinta's need for such high-tech interventions and have helped locate where to find these services and equipment. The funding of these services and equipment, however, has nearly brought my family to the brink of bankruptcy because of high out-of-pocket medical expenses, and has been an exercise in frustration and sheer terror.

When I was given the diagnosis of Jacinta's illness, and the poor prognosis that came with it, I thought at the time that it would be Jacinta's brain disease that would be the biggest threat to her life. Little did I realize that those fears for her life would come from a lack of policies that could protect and support families like mine, and by the very same health care system we think is there to cover us when we need it the most.

Lack of family and medical leave caused my family to lose health care coverage approximately 5 years ago. Jacinta's father was asked to leave his job because he had asked for leave when our daughter was in the pediatric intensive care unit for almost 4 months.

Earlier this year, we lost health care coverage again because the HMO which provided Jacinta's coverage through her father's employer, dropped the entire company because of the high amount of claims submitted. Just prior to the HMO's dropping of coverage for the company, my family had filed a lawsuit against the HMO because they were trying to get out of paying for home health services and durable medical equipment—provisions that were included in our health benefits package.

In January of this year, I came before the Subcommittee on Children to support and encourage passage of the Family and Medical Leave Act. Lack of family and medical leave left every family living in this country vulnerable to financial devastation and a huge amount of personal pain that can never be compensated for.

We must continue down the road the family and medical leave began us on. Passage of FMLA was a first step, and an important one, but there is still so much more that needs to be done. Health care reform is the logical and necessary next step that must be taken.

In my role as health financing advocate to families, I can tell you first-hand about the horrors families are facing in trying to obtain funding for health care for children with special needs. I see how our current health care policy is based on an acute care bias. That is, health is defined as the absence of illness or symptoms. It does not allow for a wellness definition, a functional capacity definition, or a prevention of progression definition, all of which are essential

for children and adults with disabilities and chronic health conditions.

I can tell you about a family in Groton, CT whose child has been in one of our State's larger general hospitals for the last 16 months, and she cannot come home because she has no health insurance coverage. Her health care needs exhausted her million-dollar policy that she had through her dad's employer. Her doctors feel she is ready to come home, where care for her medical needs could be met by a home health agency and her parents, and probably at a cost that is considerably lower than what it is costing for her stay at the hospital.

Her parents have been unable to find an insurance plan that does not have long waiting periods on pre-existing conditions, and most have limited coverage for home health care.

Our present health care policies have effectively denied this child the right to live at home with a family that wants and, more importantly, needs her with them. What are we saying to the siblings of such children? What are the long-term effects of the huge amount of stress our families must endure?

Even when families do have private insurance, the plans usually do not meet the comprehensive needs of children with complex health care needs. Approximately 87 percent of the more than 300 families that I have worked with on my project in the last 10 months have some type of private insurance coverage. Most of these families are the "working poor"—too much income to qualify them for any type of public program such as Medicaid or Title V, but not enough for them to purchase a more comprehensive package of benefits.

Our present system allows for insurance companies to almost arbitrarily deny coverage on claims submitted because they feel something is not "medically necessary," even when there is clear, concise documentation from physicians that services are indeed necessary.

Limitations on home health care, therapies, and caps on durable medical equipment, narrow definitions of what is medically necessary do much to threaten the well-being, indeed the very lives, of children with special needs.

Providing for these children's health care needs at the time they are needed can do much to prevent further complications and more costly and intrusive medical procedures in the long run.

As the mother of an 11-year-old child who has been through many painful medical procedures, I have quickly come to know the intimate details of my child's disease. I can tell you I have an instinctual need to spare my daughter as much pain as I possibly can.

I love my daughter and would move heaven and earth to ensure that her needs are met. Often, I feel that I am moving heaven and earth to meet her medical needs. And I ask: Why? This is a question that is echoed by probably all of the families I have the privilege of serving. Why do families have to spend so much precious time and energy fighting for the funding of our children's health care needs? For some of us, this is time that could and should be spent creating much-needed memories. This time is being robbed of us.

As you start to consider health care reform, I urge the committee on behalf of the families that I represent and the families that you represent to remember my daughter and the millions of children and adults like her when you discuss what should be included in a federally-guaranteed benefits package. In doing so, you will be ensuring that everyone, including children with special health care needs, has equal participation in our Nation's health care system, and not burdened with disproportionate costs.

I applaud President Clinton for the keen insight he has shown on this critically important issue, and I thank him for taking the lead in supporting families in our country.

Thank you.

Senator DODD. Thank you, Eva, very much.

[The prepared statement of Ms. Skubel follows:]

PREPARED STATEMENT OF EVA SKUBEL

Good morning Senator Kennedy and distinguished members of the Labor and Human Resources Committee.

My name is Eva Skubel, I am a resident of Moodus Connecticut. I am the coordinator of the Health Financing Advocacy project in the Family Center, at Newington Children's Hospital, a facility that has an outstanding reputation for serving children for almost one hundred years.

I am also a Connecticut coordinator for Family Voices, a national coalition that represents children with special health care needs in the discussions on health care reform.

I am the mother of three children, one of whom was born with serious and complex health care needs. These needs began my personal journey of experiences in the present health care system, and it's failures to families like mine.

My oldest child Jacinta, was born with a rare brain disease. The nature of her illness requires that she be under the direct supervision of a full 12 hours of nursing care.

Essentially I have in my home a mini hospital, with oxygen tanks, a C-Pap machine, blood oxygen monitor, suction and feeding pumps. These pieces of durable medical equipment and the presence of nurses in my home, are absolutely necessary in keeping Jacinta out of the hospital and alive.

Highly skilled and dedicated health professionals have assisted my family's understanding of Jacinta's need for these high tech interventions, and helped locate where to find the services, and equipment. The funding of these services and equipment however, is a twenty four hour battle for me, an exercise in frustration and sheer terror.

When I was given the diagnosis of Jacinta's illness, and the poor prognosis that came with it, I thought at the time, that it would be Jacinta's brain disease that would be the biggest threat to her life. Little did I realize that those fears for her life would come from a lack of policies that could protect and support families like mine, and by the very same health care system we think is there to cover us when we need it most.

Lack of Family and Medical Leave, caused my family to lose health care coverage approximately five years ago. Jacinta's father was asked to leave his job because he asked for leave when our daughter was in the pediatric intensive care unit for almost four months.

The HMO which provided Jacinta's coverage, through her father's employer, dropped the entire company because of the high amount of claims submitted. Just prior to the HMOs dropping of coverage for the company, my family had filed a lawsuit against the HMO because they were trying to get out of paying for home nursing and durable medical equipment that was included in our benefits package.

In January of this year I came before the Subcommittee on Children to support and encourage passage of the Family and Medical Leave Act. Lack of Family and Medical Leave, left every family living in this country, vulnerable to financial devastation and a huge amount of personal pain that can never be compensated for.

We must continue down the road that Family and Medical Leave began us on. Passage of FMLA was a first step, and important one, but there is still so much more that needs to be done, Health care reform is the logical and necessary next step that must be taken.

In my role as the health financing advocate to families, I can tell you first hand about the horrors families are facing in trying to obtain funding for health care for their children with special health care needs.

I see how our current health care policy is based on an acute care bias. That is, health is defined as the absence of illness or symptoms. It does not allow for a wellness definition, a functional capacity definition, or a prevention of progression definition, all of which are essential for children and adults with disabilities and chronic health conditions.

I can tell you about a family in Groton, CT whose child has been in one of our states larger general hospitals for the last 16 months, who cannot come home because she has no insurance coverage. Her health care needs exhausted her million dollar policy provided by her Dad's employer.

Her doctors feel her child is ready to be discharged home, where care for her medical needs could be met by a home health agency and her parents, and probably at a cost considerably lower than what it is costing for her hospital stay. Her parents have been unable to find an insurance plan that does not have long waiting periods on pre-existing conditions and most have limited coverage for home health care.

Our present health care policies have effectively denied this child the right to live at home with the family that wants, and more importantly, needs her with them. What are we saying to the siblings of such children? What are the long term effects of the huge amount of stress our families endure?

Even when families do have private insurance, the plans usually do not meet the comprehensive needs of children with complex health care needs.

Approximately 87% of the more than 300 families I have worked with through my project in the last ten months, have some type of private insurance coverage. Most of these families are the "working poor"; too much income to qualify them for any type of public assistance such as Medicaid or Title 5, but not enough for them to purchase a more comprehensive package of benefits.

Our present system allows for insurance companies, to almost arbitrarily deny coverage on claims submitted, because they feel something is not "medically necessary" even when there is clear concise documentation from physicians that the services are indeed medically necessary.

Limitations on home health care, therapies and caps on durable medical equipment, narrow definitions of what is medically necessary, do much to threaten the well being, indeed the very lives of children with special needs.

Providing for these children's health care needs at the time they are needed, can do much to prevent further complications and more costly and intrusive medical procedures in the long run. As the mother of an eleven year old child who has been through many painful medical procedures, I can tell you there is an instinctual need to spare your child as much pain as you possibly can.

One evening about six weeks ago, I received a call for a mom that I had been working with in getting coverage for her twenty month old daughter who had a degenerative brain disease. She asked me if I could please come over, that her daughter didn't look quite right.

When I arrived at the home, the mom was in an obvious state of shock, trying to comfort her eight year old son. The baby was barely breathing, I called an ambulance and began CPR. The mother asked me if I would accompany the child in the ambulance to the hospital because she knew in her heart that her daughters illness had progressed to the point where her son required her presence more than her daughter did.

The hospital personnel tried everything, but the baby didn't make it. I then had to do what was the hardest thing I have ever done in my entire life. I went in and kissed the child goodbye for her mother and father, and then placed a phone call to the family and told the mom that her daughter had passed away.

Her response to me was a question. A question that I hear echoed in probably all of the families that I have had the privilege to work with. That question was, "WHY?" Not, "Why my child?" Families somehow come to a peace with that in one way or another. Not, "Why did my child die?" Parents quickly come to know the intimate details of their children's diseases. The question was, "Why did I have to spend so much precious time and energy fighting for access to the health care that my child so desperately needed?" This was time that could have, and should have been spent creating much needed memories. That time was robbed of them. Every day I live with the sadness of knowing that I could very likely be the next one asking, WHY? Before it comes to that I come before this committee in behalf of the families I represent and the families that you represent, not asking "Why is the present health care system allowed to do this to families?" But, "When are we going to change it?"

Senator DODD. Joseph, thank you for being with us today.

Mr. MEDLIN. Thank you.

Greetings. My name is Joseph Medlin. I am 17 years old, and I attend Far Rockaway High School in Queens. I am also the captain of the Far Rockaway High School basketball team. I plan to be a broadcasting technician in the future, but the only way I can achieve this goal is to stay healthy. That is why I go to the school-based clinic in my school.

The school-based clinic is always there when you need them. I have gone over 20 times since I came as a freshman, and they have helped me with my injuries and sicknesses that I have had. And when you want to join a high school team activity, you can get a checkup and begin playing right away, instead of waiting days to get an appointment with another doctor.

Also, if somebody gets hurt during gym, sometimes there is no time to run to the hospital. When you need some care, the clinic is right there. I know the school-based clinic in Far Rockaway High School takes good care of us, and they keep everything confidential.

There are youth in my school like me who are part of an HMO, but they would rather go to the clinic than to their own doctors because they feel more comfortable. I would rather go to the school-based clinic because it is easy, and they treat me right. I have gone to the clinic for more than injuries and illnesses. I have seen the dentist, too. We even have a therapist that listens to people when they are depressed, have a problem, or need a solution. That can be really important, and it has helped me and a lot of my friends. Instead of going her for a doctor, over there for a dentist, and down the road for a counselor, wouldn't it just be easier for kids just to go to school, where everything is available in the school-based clinic?

I know friends who have been treated in the clinic and stayed in school, instead of going home and missing classes. It helps kids to stay in school if they know somebody cares about them. If you go to the clinic, and they find something seriously wrong, they contact your parents and refer you to a specialist to do other tests.

I remember 1 day last spring, I had tendonitis and a lot of players had hurting bones, and they were in pain. The school-based clinic called in an orthopedist to see us all, and he prescribed some medication. Now the pain is all gone, and we can play.

The clinic also provides help for girls who might need a pregnancy test. It is not easy growing up in Far Rockaway. I have friends who have gotten into trouble because of drugs and other problems. The school-based clinic has treated them and helped them with their lives.

I think school-based clinics should be in all high schools like ours. I am very glad that I have had one to help me out the last 3 years.

Thank you for the chance to come and tell you about my experiences this morning.

Senator DODD. Thank you, Joseph, for coming; very well-spoken. I appreciate you sharing your thoughts with us.

We have been joined by our colleague from Vermont. Jim, do you have any opening comments you want to make?

Senator JEFFORDS. Not really. I would like to hear from the witnesses some more, and I will make some comments at that time.

Senator DODD. All right.

Dr. Brazelton, let me ask you a basic, fundamental question.

You were talking about prevention, and one of the things we care deeply about is seeing to it that prevention is a critical element of this health care package. Howard Pearson will be testifying shortly, a good friend from Connecticut, speaking on behalf of the American Academy of Pediatrics, a remarkable group of physicians, in my view.

But I have got to tell you that other than the Academy of Pediatrics, a few others, and people like yourself, the health care profession is pretty silent, in my view, on the issue of prevention. I have got to say that candidly. I mean, we talk about it; you get families who come forward who have been through experiences. Is that changing? That is going to be very difficult.

Mrs. Clinton cares about it. She worked, of course, with the Children's Defense Fund for many years and has been sensitized to a lot of these issues and articulates them better than anyone I have ever heard before. But frankly, I do not get the sense, with all the other players involved in this and with all the other things they talk about, that prevention is quite as high on the agenda as it should be, particularly from the provider community. And I am obviously exaggerating a bit here because individual cases are different. But when you generally hear from health care providers, this is not a subject that is talked about. Is that changing?

Dr. BRAZELTON. I sure hope so. I do not see as much change as I would like, either. In fact, when Bill finished his speech, as he walked out, I said, "You know, Bill, the one thing you left out was that if we paid for prevention early and front-loaded it, we could pay for all of the costs out here."

And one of the other things I feel about prevention is that we could turn back health care to people. We could share it with them. I think the medical profession at this point is monolithic. It hands down goodies to people, and they either pick them up, or they do not. But I think if we really empower people, like Ms. Morrison, we could expect them to take some responsibility for their own health care, and that would cut down costs enormously.

So aside from the costs—that ought to be our first thought that, gosh, we could save everything we need to save if we pay for prevention, and we could cost that out, and I hope we are in the Academy of Pediatrics, because it is a major step.

I think it has to do with private interests. I just do not think people really want to hear about this coming from the lawyers, drug companies, and insurance companies, and you all are really being pushed around by them down here—I know, because I have been pushed around by them myself.

But I think if we do not pay for prevention, we are not going to make any impact with our new bill. And to think about universal health coverage without paying for prevention would not be much of a step, I do not think.

Senator DODD. You will not have a single argument from any one of the people sitting on this panel right now on what I am about to ask you. But I am going to ask you this question because I do

not think it is well understood by others. Dr. Brazelton, why is it so important that a child get appropriate health care in the first 5 years? Why is that so critically important? Maybe we are not getting that message out effectively enough. I have heard you talk about this, and certainly my colleagues here have, but I wonder if you might just take a minute or two and explain why it is so critically important, and why it makes such a difference.

Dr. BRAZELTON. Well, I think you could take it in almost any developmental line that you know of. I have this wonderful thing from UNICEF, which I would like for you all to keep. We are 21st and below the mean for the world on measles immunization. Imagine. That is crazy. And it is because people have to pay \$120 to get a measles shot these days. How many people can afford that?

But the main thing for me is that if we could get in early in pregnancy and reinforce people for their burgeoning desire to have that baby, to have that baby perfect, to do all they can about making that baby perfect, we would have them right in our pocket by the time the baby came. Then we could use the new baby to reinforce for attachment, for feeling good about themselves and about their baby, and each step of the child's development could be used in a preventive way and a reinforcement way to make people feel like, "I am making it. My baby is making it. I know what I am doing."

We know how to do that, and we are setting it up to do that with the privately funded outreach programs now. Why can't the Government take that on as a challenge? If we know how to do it, why couldn't we set up the new health care preventive health bill to really capture people back here, not only for disease, but for emotional development, for cognitive development, and all of the things that we are paying such a terrible price for in this country. And I think we could combine them. Head Start showed us that putting medicine and development together was more than just adding them; it was synergistic, and the gains that came out at ages 14 and 15, all of the beautiful things that we have learned about Head Start, in which kids were no longer being incarcerated, and are now contributing to society and so on, all of those could be accounted for health gains as well as emotional and cognitive gains. But put them all together—you have got them.

This is where I think we had better start thinking in this country. We are in terrible trouble in this country. I went to Yugoslavia this year to see what had happened there, and I came back not only sick after talking to those kids, but I thought on the way back, you know, this is just like us. We are right around the corner. Los Angeles was telling us we have got the same ethnic hatred just ready to boil up. The violence in all of our inner cities is telling us we are not meeting people's needs. And you begin to ask, well, what will we do about it—I think we have got to start early. And if we do not start with parents and children and giving them back a feeling of attachment and of feeling good about themselves and feeling safe about their health, which we sure know plenty about, I think we are missing a very, very scary opportunity. I do not know when we will ever have another one like it.

Senator DODD. I agree.

Eva, briefly, you cited a couple of examples, the Groton family, and so forth. I think there is a tendency for people to say that,

well, those are sort of isolated examples. You are there every day with that advocacy group at the Newington Children's Hospital. How common is this, really?

Ms. SKUBEL. I serve families not only—

Senator DODD. How many do you work with?

Ms. SKUBEL [continuing]. In the last 10 months, I have served close to 350 families, and in the Family Center, we have worked with over 1,000 in the last year. And we do not only serve children who are seen at Newington Children's Hospital, but across the State. And I wish my story and the Groton family were an exception, but we are not. I feel like I am going around putting bandaids on families' problems, and I am running out of bandaids. Families are desperate.

I have families who have insurance coverage, and their insurance is covering 85 percent of what is reasonable and customary, and they are ending up with \$37,000 hospital bills above what the insurance covered. So these families are desperate, and it is very common.

Senator DODD. How did the advocacy group get started, and what is the reaction of the medical community at Newington to the advocacy center?

Ms. SKUBEL. The Family Center was created because we knew that in Connecticut, there was a lack of an entity that families could go to to find out about resources available in our State. There was a lack of advocates who could advise families about their rights under our special education laws and the complex health care system that we have in existence right now. Families do not know how to access it very well. There is not a lot of outreach done by the public agencies on how to access these programs. It is very difficult to move through these systems.

So we started with that in mind and have kept data on the issues that families are calling about and funded projects that meet those needs.

Senator DODD. What is the reaction, generally, to this?

Ms. SKUBEL. From the families?

Senator DODD. Well, from the medical community. I mean, you are talking about a very complicated system. You do not plan on these kinds of things happening. They just hit. I am familiar enough with it, but you almost need to hire a law firm to take you through this—forget a lawyer—a law firm—just to weave your way through the maze of trying to figure out what is available out there. I am not talking about people who are desperately poor. I am just talking about people who can access the system now to get help. It is unbelievable how complicated it is.

So what is the reaction of the medical community, how do they react?

Ms. SKUBEL. Well, I think if you look at the referrals by different medical facilities across the State, you would know that their reaction is a positive one. They are at a loss as to how they can serve families, and they do not understand the intricacies of the different programs that are in existence. So the large number of referrals reflects that they are very positive about this. And we help them recoup a lot in medical costs.

Senator DODD. Dr. Brazelton.

Dr. BRAZELTON. I think also that a child with the complications that you were talking about cannot be handled by a medical person, so it has to be a multidisciplinary team, and this is what happens in a center like yours, and that makes it possible to give them what they need.

Ms. SKUBEL. I use this analogy when I describe the Family Center's services as opposed to maybe a social worker's services. I liken a social worker to a travel agent, and a parent consultant from the Family Center as a person who has been to the country. They both have their roles. When you make plans to go to a country, you will go to a travel agent to purchase your tickets, and he can give you a general description of the packages that are available, but they may not have been there. And parent consultants are the people who have been to the country. We know to say, "This is where you go for this," "Don't drink the water," and so on.

Senator DODD. That is a good point.

Thank you both. And Lynn and Joseph, let me thank you immensely for your testimony as well. You have been very, very helpful to us here this morning.

Senator Kassebaum.

Senator KASSEBAUM. Thank you very much.

I think everybody spoke quite eloquently to the needs that are there. I was particularly struck, Ms. Skubel, by your comment on the stress to families, because that really was apparent as well, Ms. Morrison, with your case. I think that is what is apparent for so many families who either do not have the insurance to cover their special needs, or do not have insurance and do not know where to turn.

I would like to ask you, Mr. Medlin, a bit about the school-based clinics. I think you spoke to the importance of them in reaching your average health needs to a certain extent. From your experience, and knowing the students there at the high school, do you think that high-risk students use the health clinic?

Mr. MEDLIN. Yes.

Senator KASSEBAUM. So you see everybody, more or less, going there?

Mr. MEDLIN. Yes.

Senator KASSEBAUM. If we had more community health centers, with the primary care providers at the community health centers, from your experience of students using the school-based clinics, do you think they would choose to go to a community health center over the school clinic, or would you be able to know what difference that might make?

Mr. MEDLIN. I would not know about that, but I feel that since I have been in the clinic, everybody is comfortable coming to the school-based clinic. We even have other schools come to our clinic.

Senator KASSEBAUM. I would say you have a pretty good clinic.

Mr. MEDLIN. Yes.

Senator KASSEBAUM. And maybe that is what it takes for students who are acknowledging that it is important to go, and leaders such as yourself, because I have heard from some other students who say, well, there is a certain stigma to going to a school-based clinic, and they really do not know that they want to be seen going to a school-based clinic.

So I think a lot of it must have to do with the atmosphere and the students' acceptance of it. So I am pleased to hear you say that you feel high-risk students use it as well, and that everyone feels comfortable.

Mr. MEDLIN. Yes. Even if you do not even have insurance, they still check up on you.

Senator KASSEBAUM. Well, I feel sure that you do not even have to have insurance, necessarily. Would you use the clinic for basic tests?

Mr. MEDLIN. No.

Senator KASSEBAUM. No.

Ms. Skubel, I would like to ask you regarding your child's care. I assume it would really have to be long-term care benefits that would be of any real assistance to you; is that right?

Ms. SKUBEL. Absolutely. To call them long-term care, to kind of separate it out—

Senator KASSEBAUM. To separate it out from the elderly.

Ms. SKUBEL [continuing]. I would like to see it included in the federally-guaranteed benefits package. You know, we have the ADA that gives civil rights to people with disabilities, and for it to really have meaning, we need to develop all future policies with that in mind and incorporate all people's needs into whatever programs we develop.

Senator KASSEBAUM. While I have believed that it would be very difficult, actually, for either Congress or the administration to set what is in the benefit package—and in a concept that I worked on, I believed it should be an independent commission somewhat like the Federal Reserve or the Base Closing Commission, that would have enough independence that they could determine what those benefits should be—but I have also believed that the one benefit that I thought it was very important to be in there and be determined to be in there was long-term care, simply because it is an enormous problem, not only for those who are younger, with special needs, and a lifetime of care, but also for the elderly. And demographics are changing, and we are all living longer, so it seems to me it is important that my children should have to carry it in their 30's in order to spread out actuarially the costs over a large enough portion of the population.

But I think it particularly hits the young and the stress on families for, whether they be injuries that can occur on the football field that require, then, a lifetime of care and rehabilitation, or for just those who have had to divest themselves of all their assets so they can be eligible for Medicaid for elderly care.

So I just wanted to ask you if that was probably the only real aspect of benefit coverage that would be of assistance to you.

Ms. SKUBEL. Would that be the only—

Senator KASSEBAUM. Well, I would assume that would be the major, rehabilitation or long-term care.

Ms. SKUBEL. Home health services; those services mean the difference between our children living at home with us, or adults with disabilities living independent lives, or being placed or having to go to an institution for their care.

I know that health care costs for my daughter are extremely high, and a lot of people would say that she is a burden to society

and people like her are a burden to society, a financial burden. But she is not the one who puts the price tag on those services. She does not see a penny of any of the dollars that are spent on her care. I like to say that Jacinta is a multimillion-dollar industry unto herself in that she creates a lot of jobs for a lot of people. And the provision of services for people like her creates a lot of jobs for a lot of people. The economic devastation that would take place if she were not there, and her needs were not being met, would be devastating to this country.

Senator KASSEBAUM. Thank you very much.

Thank you, Mr. Chairman.

Senator DODD. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

I have one or two questions, but I first wanted to thank Mr. Medlin for his testimony. And I wanted to tell you that I believe, just to brag for a moment, that Minneapolis-St. Paul may have had the first school-based clinics. I know from visiting them, that much of what you said is exactly what happens.

I would say to Senator Kassebaum that I think it does depend upon the way in which those clinics get set up and who the nurses are doctors are and how they relate to the students as to whether or not there is a stigma. It used to be that when we were in school, the clinic was somewhere you went either when you had the flu or when you were pretending to have the flu in order to go home. [Laughter.] But now the clinics have become family doctors in our communities, and I really think what you said was very, very important.

And I wanted to say to Ms. Morrison that I, just like everybody on this committee, really appreciate the power of what you said. It seems to me that one of the things that quite often we do not understand, and it worries me when we start thinking about means-testing some of these programs, is that there are a lot of citizens in our country who are not poor enough for Medicaid—although I think that is by no means comprehensive—and they are not old enough for Medicare, which in any case does not cover long-term care, but they are not able to purchase a good private health insurance plan. And that actually ends up being the majority of people in this country, especially given the current trend.

I have two questions, and I will start with you, Dr. Brazelton, if I could. When Ms. Skubel talked about the “why” questions, she said that with a lot of power and then thanked the President for focusing on the importance of universal coverage and a good package of benefits. I want to thank the President, too, so I will start out in a positive way, because I am about to express some reservations. I think it is a good package of benefits. And I would say to the chair that when I meet with doctors, I am surprised that a lot of doctors, and not just the pediatricians or the family doctors, are now saying that as they look back at their medical education, they wish there had been more of a public health orientation, they wish there had been more of a focus on preventive health care. I think it is starting to go in that direction.

Here is my concern about the President’s plan, and I would ask any of you to respond. I was listening to some of the discussion about HMOs. I am worried that if you may have in your States,

on the one hand, these accountable health networks that compete against one another to keep costs down, and you have alliances that in some sort of way are going to represent consumers and buy the best plans for consumers and somehow monitor these networks. But if in fact on the other hand, as is reported in all of the newspapers, you have got your Humanas and so on that are moving in and buying up these networks, and they are competing to keep costs down, I would think from the point of view of the most vulnerable populations that there is going to be a disincentive in terms of marketing, in terms of location, in terms of access or lack of access to services, in terms of whose phone calls get responded to. I do not see the infrastructure of community-based health care that really reaches out into the communities, especially those populations that are the most vulnerable and the weakest, politically and economically.

I guess that is a question that I would like to ask. Earlier this morning, I was listening to National Public Radio, and they reported that today there was going to be a show on where they were going to talk about the irony that in this new health care plan, the poor may in fact not fit in well; they may in fact fall between the cracks.

I wonder if you have any concern about that, and then I would add a second part to this if I could, which is that I really worry about the concept that there is going to be an average-price plan, there is going to be a low-cost plan for those who cannot fit into the average-price plan, and then people can buy up into yet another price plan. I am wondering whether we are not going to create more Medicaid's. I am worried whether we are not going to create a lot of stratification. And to lay it out on the table, Dr. Brazelton, since you said this, I am worried whether or not this is not going to get pretty much dominated by the insurance industry when all is said and done, and we are not going to be able to really have that focus.

Dr. BRAZELTON. I agree with you entirely, with every point you made.

Senator WELLSTONE. Well, let us just end the hearing at this point. [Laughter.]

Dr. BRAZELTON. I think it is absolutely what we all ought to be fighting for. I do not see this medical care system as getting in place in the next few years, but I think in those next few years, this is exactly what we ought to be fighting for.

I can tell you, though, that at Harvard Medical School where I teach, I was called over by the dean yesterday to talk about changing our curriculum to fit how do we reach out for people, how do we begin to make relationships with people, and how do we use them to get them into the system. This is brand new, and it may be occurring in other medical schools a lot earlier than this. But I was very encouraged, and it was because of this health plan.

So I think we ought to fight for all of the things you are talking about. If we are really going to make this universal coverage, is it going to be universal? Are we really going to be reaching out for people?

Senator WELLSTONE. Right.

Dr. BRAZELTON. We know how to do that now, that is the thing. If we want to reach them, we have to reach out; we cannot let them fall through the cracks because they are not reached. And I think it is going to take a whole new vision of medicine, which is very exciting to me.

Senator WELLSTONE. I think one of the things we could make sure of is that if you have networks of community health care clinics and others that really want to have a strong community outreach, that really want to relate to citizens who feel empowered, they should have access to capital so that they can set up their own network without having to hand out an Aetna sign, or some big for-profit here and there—because I frankly really worry that I do not really see that some of these big outfits are going to be all that interested in what we are talking about here.

I wanted to ask a question about long-term care. On the formula of Activities of Daily Living, I am an unabashedly strong supporter of the single-payer approach, and in our bill, we say two Activities of Daily Living, not three, to be eligible.

Do you have any feeling about that? I mean, we are trying to make it as generous as possible and tilt it toward—

Ms. SKUBEL. We do have some concerns about that. There are children who are technology-dependent who would not meet your criteria, who function—like Katie Beckett, who is on a ventilator—who can function pretty much normally but have the need for high-tech medical interventions, and Katie would not fit into that criteria if we were to use that right now. So there would be a lot of children who would still be falling through the cracks.

Senator WELLSTONE. And would not be eligible for the—

Ms. SKUBEL. Right, right.

Senator WELLSTONE. OK. That is something I think we absolutely ought to keep in mind.

Did any of you want to respond to that first question that I raised as to whether or not you have any concerns within this framework of alliances and competing networks, competing to keep costs down, that maybe from the point of view of—I mean, unfortunately, children are disproportionately among the ranks of the poor, and if we are talking about those people who are on the very bottom economically, whether there may be almost a disincentive to serve those people, and we have got to make sure there is an infrastructure of community-based care.

Ms. SKUBEL. I think that not only children who are poor, but middle-income families—we are not sure yet; the President's plan is not addressing yet what is going to happen to children who are served under Medicaid waivers, and what is going to happen to EPSDT. So until we know for certain what is going to happen with those programs, those children, if they are not addressed, are not going to be served.

I think there is a disincentive to serving these populations if we do not have good coordination of their care. And when they are talking about if you want to purchase a more comprehensive benefits package, and that there will be a tax on that, I am afraid of what is going to happen to what families are paying in terms of out-of-pocket medical expenses, which are going to be huge.

Senator WELLSTONE. Absolutely. I think there is a real question on the affordability issue. Absolutely.

Ms. SKUBEL. You are talking about a tax, an extra tax, plus what you are normally paying in—that 25 percent or 20 percent that employees would be paying, plus out-of-pocket copayments. That is a huge amount of money.

Senator WELLSTONE. Well, I will conclude. The chairman has returned. But just to build on your point, I actually do not accept the premise that the major reason for the explosion of costs is because of overutilization by consumers. I think it is far more overutilization by providers. And one of the things that really worries me is that—it goes right to what we are talking about today—if we are not careful, all in the name of making sure that the consumers do not overutilize—I hear that a lot from some of the doctors—we are going to have copays and deductibles that are going to undercut preventive health care, because people are not going to come in at the front end if in fact it is too much of a chunk of their income. We are going to have to be very careful about that.

Ms. SKUBEL. I would urge you, too, to keep in mind that prevention is extremely important, but there are also children who are born whose mothers have had excellent prenatal care, and you are still going to have people born with disabilities or chronic health care needs, or this will happen later on in life, so you need to look at this population and realize that even huge amounts of preventive care are not going to be the solution.

Senator WELLSTONE. I do not know if Senator Dodd was in the room when you made the point about your concern as to what kinds of children with disabilities might fall between the cracks. You talked about some who may not fit into the definition of Activities of Daily Living. Could we get something in writing from you on that? I certainly would like to have that in writing.

Ms. SKUBEL. Yes, certainly.

Senator WELLSTONE. Thank you.

Thank you, Mr. Chairman.

Senator DODD. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

This has been an excellent panel, and I appreciate your testimony.

I spent an exciting day yesterday at the Detroit Children's Hospital and the Michigan Medical Center. They say they have the best children's hospital in the country, but I think that, Eva, you may disagree with that. Anyway, it was an exciting time to see what can be done if they have the chance to do it. I think that was one thought I left with was the recognition that even with the availability of such an incredibly good hospital, there are a large number of low birth weight babies who come in who need intensive care, needlessly in the sense of the inability of preventive health care. So I am deeply interested in the preventive health care aspect.

Also, another interesting experience I had this summer was being in Taiwan and meeting with the minister of health there and going over their situation with respect to infant low birth weights of which they had practically none, because culturally, their people swarm in when a woman becomes pregnant, and ensure that there

is adequate food right on up through the period of life where it is necessary. It was just amazing to find out that that is not their problem—although they are going through health care reform and looking to us for guidance, which made it kind of interesting to think that they would be looking to us for guidance when they have had that kind of experience.

But those experiences pointed to how important and how doable it is to have good preventive health care, especially for infants. And I am ashamed of the fact that we are 19th in the world in infant mortality.

But what I came away with yesterday was that notwithstanding the fact that they have a fairly good WIC program and so on, they still have a large number of premature and low birth weight babies, and the need for us to do something. I think the thing that is really startling to me is how much we can do for so little in preventive health care that we do not do.

If something like 2 or 3 percent of our budget were spent on preventive health care, it would do so much relative to the costs; and just half a percent of our health care expenditures in nutrition would probably provide all the nutrition needed to prevent those low birth weight babies.

But the problem, as I left Detroit, is the nonavailability of the guidance of the primary physicians in the inner cities in particular, and what can be done to try to improve that.

It was interesting talking with the officials from the Michigan health center. They see the need under the President's health program that they must take the responsibility for getting the primary health physicians out into those areas, and it is for self-interest as well as the interests of children, because if they do not have the flow of patients going through their health centers, then they are going to have cost problems. So that was interesting.

Dr. Brazelton, I would like your thoughts on what we need to do to be able to get especially pediatricians and primary health physicians out into the areas of the rural poor, or the inner city, and Eva, your comments and perhaps others, on what we need to do and whether the Clinton plan, which has some assistance in this area, is going to do it, or do we need to do more.

Dr. BRAZELTON. Well, I think the obvious thing is that we need to do a lot more. I think we need to start with training physicians differently so that they are more patient-oriented and less disease-oriented, and I think this bill is beginning to push people to realize that. Most medical schools—Howard Pearson and I were talking about this—are now taking about training more family physicians and fewer specialists, which is certainly a symptom of that. But I think to lose out on training this people as experts would be tragic.

What I think would help—and I think this bill allows for that, as I understand it—is to set up multidisciplinary clinics in each of these centers—rather than expecting one person to do it all, which is just almost impossible, have a group of people who are working together, all with the same value systems, the same interests, and so forth. We are learning a lot. We are developing, as I said, a curriculum to go with outreach programs around the country, and we are learning that we can speak other ethnic groups' value systems, and we can talk about the wide gap between upper middle class

or working class and lower class people's value systems. And once we begin to do that, the excitement of interacting with people and of having people come to you—like when Mr. Medlin talked about the school-based clinic, he just really turned me on—I want to run a school-based clinic now, because it sounded like that would be so rewarding. And this is what people have gone into medicine for all through the centuries, and I think now they will have a chance, if it is paid for and protected, to get back to that. But I do not think it ought to be thought of as monolithic doctor to patient as much as a group of people working together with a group of patients, who can bring all of their troubles to the clinic. And I would like to see these not just medical clinics, but socioeconomically valid clinics, too.

Senator JEFFORDS. What about education, especially health education and education of pregnant women? How are we going to get that out? Eva, do you have any comments on how we are going to get into the poor areas, whether they are rural or urban, and how we are going to get the information available so that they know to go to a health clinic and they know what is available?

Ms. SKUBEL. I frequently hear service providers, medical providers, complaining about Medicaid clients, that they do not make their appointments, that they utilize services in the hospitals wrong. And I think it is important that we stress coordination of care at a community level. Insurance companies put together beautiful packages of explanation of benefits for their clients. Why can't we do the same for people on public assistance? I do not think anyone enjoys sitting in an emergency room at 11 o'clock at night. I do not think that is something people intentionally do.

We educate families, consumers, as to where they should go and when they should go for certain types of medical care. I think you would be doing much to solve that problem.

Senator JEFFORDS. Of course, they have to have someplace to go before we can do that, too.

Ms. SKUBEL. I think Dr. Brazelton is right in that. You have to start in the medical schools and start training physicians on family-centered care, why it is important, how to relate to families, and how to be on a person-to-person level. That is where you start.

Senator JEFFORDS. Dr. Brazelton.

Dr. BRAZELTON. Were you here when I mentioned what France has done, paying \$1,000 to every pregnant woman for four prenatal visits? They have reduced their infant mortality to one of the three lowest in the world now, in 2 years.

But I think besides the financial repayment, there are other kinds of repayment that may be a lot more critical to people than Ms. Morrison's testimony brought out. If she had had any feeling of being supported for this stress she was in, it would have been a hell of a lot more important than \$1,000 could have been. This is what I think we need to tie to this new medical bill. Whatever we do, we have got to tie that in, and that is going to take education of the whole medical system and the public. I think the public, and all of us, ought to spend the next 3 or 4 years educating ourselves about how this will work. So I do not see it as going just like that.

Senator JEFFORDS. Lynn, I want to say that your testimony was incredibly compelling as to why we need something like the Clinton health plan, because of the desperation you felt, and yet you are in that group that is trying their best and has the economic availability in the sense of talents of yourself and your husband to do something, but yet you could not do it. It is just shocking that someone trying as hard as you did was unable to get the kind of care that you needed.

Ms. MORRISON. Another think I wanted to mention was that during this ordeal, I felt so alone, and I thought we were the only ones going through this, but there are other people in the same economic status as my husband and myself who have experienced what we went through. Some lost their homes. Some lost their marriages. In the State that our society is in today, children need their parents, and you cannot put a monetary value on that. We need a good health care system that works for everyone, regardless of how much money you make, where you live, or your race or creed.

So that is something we really, really—I came here today, and I really did not want to get emotional, but I lived it again. I read this thing 20 times, but to have someone hear it and to understand what my family went through was and is very important to me. And other people go through it. We are average, working class people, and we are not the only ones that this has happened to.

So please, Mr. President, Senators, let us do something about it. Let us not let this keep happening over and over again. It is not good for our society or our children.

Senator JEFFORDS. Thank you.

Joseph, are you a senior now?

Mr. MEDLIN. Yes, sir.

Senator JEFFORDS. Have you started your ball practice yet?

Mr. MEDLIN. Our first game was yesterday?

Senator JEFFORDS. How did you do?

Mr. MEDLIN. We demolished them. [Laughter.]

Senator JEFFORDS. I am pleased to hear that.

Senator DODD. They weren't from Connecticut or Vermont, were they?

Mr. MEDLIN. No; they were from Queens.

Senator JEFFORDS. Let me get a little bit more information about your school clinic. Are there other high schools in your community, or are you the only one?

Mr. MEDLIN. This is the doctor who works in the school-based clinic.

Senator JEFFORDS. Hello. I was wondering if there are other school clinics. Is it a common occurrence in the area?

Senator DODD. Please introduce yourself for us.

Dr. FISHER. Yes. I am Dr. Martin Fisher, the medical director of the school-based clinic in Far Rockaway High School. That particular community has two high schools, one of which has a school-based clinic, one of which does not. We started 2 years ago a school-based clinic in the junior high school that sends its students on to that high school, so now we have the availability of seeing the students for 7 years straight, starting in 6th grade through 12th grade.

In New York City itself, there are approximately 20 to 25 junior and senior high schools that have school-based clinics now.

Senator JEFFORDS. Out of what universe?

Dr. FISHER. About 110 high schools and probably 100 or more junior high schools. So it is a growing percentage, but still not a large percentage.

Senator JEFFORDS. How are you funded?

Dr. FISHER. Our particular school-based clinic was funded originally for 6 years through the Robert Wood Johnson Foundation, which established a program to fund 20 clinics across the country as a demonstration to see how the clinics would succeed, and in fact they did succeed. Ours is now funded, starting this year, through the New York State Department of Health, because all of the clinics did in fact show that they were able to do what they set out to do, so they are funded through other sources. now.

Senator JEFFORDS. So you are a believer in them.

Dr. FISHER. Yes, a strong believer.

Senator JEFFORDS. Good.

Dr. FISHER. Could I comment?

Senator JEFFORDS. Yes, go right ahead.

Dr. FISHER. Each of the Senators have made points, I think the school-based clinics really cover each of those points. Senator Dodd commented on the issue of prevention, and we certainly consider the school-based clinics to be the ultimate in prevention in terms of, as Joseph mentioned, treating illnesses and injuries at the very earliest stages. The issue of immunization was raised by Dr. Brazelton, and we find, for instance, a very small percentage of our students have the proper amount of immunizations as they are in their teenage years, and we provide those immunizations, including measles, mumps, and rubella.

The issue of early prenatal care, as Joseph mentioned, there is pregnancy testing, and the students who are pregnant, we have been very successful in getting to very early prenatal care, which is one of those things that prevents low birth weight babies. When we first came to the school, we were involved in treating a lot of suicide attempts, and after the first few months, that was no longer happening. And while we cannot prove it, we believe that our presence, because we have been seeing the students for also psychosocial types of problems—family issues, school issues—we think we are preventing what ultimately were the suicide attempts because we are now seeing those students so much earlier because everybody in the school is aware of our presence, and whether it is through the teachers or the students, they know to come to us.

And then Senator Kassebaum raised the issue of the high-risk students and the fact of a stigma, and I think the key to that is if the school-based clinic is organized to treat those issues which are more in the prevention area, then it also serves to prevent the stigma of those students who have problems. So it is not viewed as a clinic for those who have problems; it is viewed as a clinic for the entire school. Therefore, those who have problems are as comfortable coming as those who are receiving immunizations, and those who are sitting in the waiting room cannot tell if one person is receiving immunization and somebody else might be getting a pregnancy test.

You also mentioned the issue of the training of physicians who then will work in poverty areas, and certainly in terms of the school-based clinics, it is highly trained nurse practitioners, physicians, social workers, etc., who really are treating the students that are at the highest risk.

Senator JEFFORDS. Thank you. I am glad I asked about your ball team, Joe. That was a good response.

Thank you very much, Mr. Chairman.

Senator DODD. Thank you, Senator Jeffords.

The vote that we anticipated 2 hours ago is now occurring, but I just want to make a couple of observations. One, as to where do you go, we have seen tremendous success with the community health service programs around our State, where comprehensive services are offered nearby. You mentioned that emergency rooms are where people go. Why can't we have outpatient facilities right near the emergency rooms. If that is where people are used to going, they will walk up and be told, "This is not where you want to be—you want to be right there, right around the corner," not downtown, not some other place, but literally as close to the hospitals as you can put those facilities. I think you could really move an awful lot of those patients in that direction.

On another issue, I am less optimistic. In our State, we provide free immunizations. The State of Connecticut pays for it all. And yet we are only serving about 65 percent of the eligible population. And I personally have been involved in programs where we have gone to places with every imaginable Disney figure you can think of, music, people out within the community, knocking on doors and so forth, to get people to come out. And we are still confounded by our inability to reach people on this immunization issue. We have just got to keep trying, but we are just not getting through in some areas.

I have often remarked that we have been able to market very effectively sneakers and God knows what else in certain communities. Why can't we market effectively immunizations, education, preventive care, and so forth? If we can get the same folks who deliver those ads for products that kids are willing to do bodily harm to their peers in order to get, we ought to be able to come up with a good promotional effort to get people to step forward and do what they ought to be doing with regard to their children.

And Dr. Brazelton, I just want to second what you said about this opportunity. I think this is one of those unique and rare opportunities. I feel so privileged to be sitting in the U.S. Senate in 1993, with an opportunity before this Congress adjourns to do something on an issue that as long as I have lived, I have heard people talk about. And I am fearful that if we miss this opportunity, if the window closes, it might be another generation before someone tries it again.

I really equate it to the debate at the turn of the century with public education, the Social Security debate of 60 years ago, and the debate on civil rights in the 1960's. This is one of those unique and rare opportunities that occurs maybe three or four times each century when society fundamentally changes the way it does things. And I just hope we do not miss this opportunity. It is so unique and rare.

And obviously, on the whole notion of prevention, the reason we are doing the hearing is to raise the level of it so that we can get more people involved and concerned about it. I am very optimistic that we are going to see a lot included in this legislation that deals with that.

And let me just say to you, Ms. Morrison, that what you did this morning, being here—and I can see Rachel's face standing behind you—you are one terrific mother; I can just tell. In addition, with all due respect—to the other witness—Joseph, you did a terrific job talking about school-based clinics; Eva obviously does a good job; Dr. Brazelton is about as good a spokesman as this country has when it comes to kids. But Lynn, I may not know much, but I can spot things, and you are a very good mother, with a lot of guts and a lot of courage. And you speak for millions and millions and millions of people in this country, and your testimony here this morning means a great deal. I want you to know that.

Ms. MORRISON. Thank you very much.

Senator DODD. And Joseph, we are going to do what we can to see that we get more support for the school-based clinics, and your presence here helps us in that regard.

Mr. MEDLIN. Thank you.

Senator DODD. On that note, I am going to excuse this panel. There may be some additional written questions which we will submit.

We will take a break for 5 minutes or so while I go over and vote, and when I return, we will get to our second panel.

Thank you all very much.

[Recess.]

Senator DODD. The committee will come to order.

My apologies to all of you. It has been one of those mornings, but we have done fairly well in getting through this, and I thank you for being with us today and hope you enjoyed listening to the first panel.

Our second panel this morning will represent the views of providers who have worked with children and with pregnant women and who can speak both to the special health care needs of these groups and the problems they face under the current system.

Dr. Howard Pearson of New Haven, CT will testify on behalf of the American Academy of Pediatrics. He will present to the committee the health care needs of children as seen through the eyes of our Nation's pediatricians. Dr. Pearson is a professor of pediatrics at Yale University and serves as medical director of the Hole in the Wall Gang camp for children with cancer and blood diseases. I have worked closely with Dr. Pearson and the Academy for many years on a number of issues. I worked with the Academy to develop and introduce S. 1456, which would guarantee children and pregnant women health care coverage.

Dr. Neal Halfon is a professor of community health sciences at UCLA. He will touch on the health care needs of our Nation's most vulnerable child populations, including those in the child welfare system. He is a pediatrician with extensive expertise on the needs of vulnerable children.

I'd also like to welcome Dr. Larry Anderson of Wellington, KS—and Senator Kassebaum apologizes for not being here to introduce

you. There is a conflict in her schedule which, in these last 2 weeks, has been a little intense in terms of time constraints. Dr. Anderson is a family physician in a 2-person practice. He has two satellite offices. His practice provides cradle-to-grave care, including obstetrics. Dr. Anderson will describe the challenge of providing maternal and child health care in rural areas.

I might point out that we have heard a lot about pediatricians, and I want to stress that family doctors and nurses and nurse practitioners and others also play a very crucial role. There is a deep appreciation for those who are out there, providing care. We have mentioned urban areas and the absence of family practitioners, but rural areas suffer easily as much and arguably have more confounding problems, because there is no place nearby that one can even go to as an alternative.

Dr. Monica Meyer is the director of the Division of Family Health at the New York Department of Health. She has specialty training in adolescent medicine. She continues to see adolescents in private practice and can speak to the unique challenges facing our country's adolescents. I would say to you, Dr. Meyer, that I happened to watch Mrs. Clinton yesterday morning on the "Regis and Kathy Lee Show"—maybe Senators should not admit that they watch some of these things, but in fact, I like the show. But aside from that, Mrs. Clinton was on it, and she talked about health care. She made specific mention—and I think one of the shortcomings in this bill—about the number of visits that we are presently talking about for 6 to 19 year olds. I am going to do everything I can to see that the number is changed and increased, and I want you to know that. But she mentioned specifically the concern that she could not please everyone, and that some people were not happy with the number of visits in the benefits package. And she is right; we are not. And if I do not get anything changed, I am going to get that changed, I promise you that, because it is really important. And you have heard about it this morning. This young fellow this morning makes that point so clearly.

So I thank all of you. I am going to do something I did not do with the first panel, only because time runs on, and people have planes to catch and other obligations. So these lights will go off in about 5 minutes or so. And you do not have to follow it exactly, but if you would just keep it in your mind so that you can sort of wrap up. And I will keep it on for myself as well, so we can keep moving along.

All of your statements, and any document you wish, will be included in the record, and if you could sort of highlight the major points, then we can get to some questions as well.

But I thank all of you for being here. And Dr. Pearson, let me tell you what a pleasure it is to see you again. You have been a terrific friend, and we are lucky that you are in Connecticut. I want you to know that having Dr. Brazelton from Harvard on first does not in any way diminish the role that Yale plays in all of these areas.

Please proceed.

STATEMENTS OF DR. HOWARD A. PEARSON, IMMEDIATE PAST PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, AND PROFESSOR OF PEDIATRICS, YALE UNIVERSITY SCHOOL OF MEDICINE, NEW HAVEN, CT; DR. NEAL HALFON, ASSOCIATE PROFESSOR OF PEDIATRICS, SCHOOL OF PUBLIC HEALTH, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, LOS ANGELES, CA; DR. LARRY R. ANDERSON, WELLINGTON, KS, ON BEHALF OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS; AND DR. MONICA R. MEYER, DIRECTOR OF MATERNAL AND CHILD HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH

Dr. PEARSON. Thank you, Senator Dodd.

I am pleased to be here representing the American Academy of Pediatrics. As you know, this is an organization with 47,000 physician members who are dedicated to the health of America's children.

You and members of this committee know well the issues confronting children and their families today. As I look at the membership of the committee and particularly you, Senator Dodd, I would be hard-pressed to find more committed advocates for children in Congress.

America's pediatricians are grateful for your work and concern on children's health issues. And I am proud to be at this hearing, the first on health care reform for children, because it marks a significant moment in the health care reform debate.

Children face many obstacles in the health care system, but one of the hardest to overcome is how most people view child health issues. They assume that in health care reform, what is good for adults will also be good for children, when the historical record in fact suggests the contrary.

The bedrock of health care debate should be: As children go, so goes our country. The importance of addressing children's health issues must not be viewed simply as an act of compassion, although that certainly is compelling. Providing children and adolescents quality health care, with an emphasis on prevention, may be the single most important economic decision that will be made during the health care reform debate.

As you write this legislation you must deal with these problems while children are young, or American will pay tenfold down the road—morally, economically, medically. Keeping children well and preventing illness makes eminent good sense.

But if this is true, and I think we accept it, why then have children had to struggle in the current health care system? Why are children with relatively minor problems such as ear infections showing up in expensive emergency rooms? Why should children with cancer or other serious diseases be at risk when their parents lose insurance? Why do young parents have trouble immunizing their children?

I do not presume to know the answers to these questions, or at least all of the answers, but I do know the problems seriously affect children and their families.

As you mentioned, one of the many hats that I wear is medical director of the Hole in the Wall Gang Camp for children with cancer and blood diseases. Living with these children 24 hours a day,

I have seen first-hand the effects that an illness like cancer can have on these children and their families. Having a sick child is one of the toughest things parents may have to deal with. Unfortunately, their anxiety is often compounded by a health care system that has gone awry.

These same families have to fight with insurance companies because insurance companies are too often making decisions about what, where, and by whom their children will get care. These families work with pediatricians who are being overwhelmed by an avalanche of paperwork and regulation.

Another obstacle to overcome in this debate is how uninsured children are perceived, and you mentioned this earlier. Many people think the uninsured are someone else's children, but that is simply not true. As you mentioned, in 1991, of the approximately 12 million uninsured children, 58 percent were dependents of full-time, full-year workers. In essence, they are the children of our working class.

Let me comment on the bills that have been submitted to Congress for consideration—and I did not, Senator Dodd, pull a “Ross Perot,” but I did bring a report card, and you have a copy of that to look at.

We realize that health care reform debate is very fluid right now, but we thought it would be helpful to provide the committee with our independent assessment of how children would fare under the various Senate health care reform plans that have been submitted. Although some significant and meaningful improvement needs to be made, there does appear to be a growing consensus among all plans with respect to children's services, particularly between the Clinton and Wellstone reform plans. However, it is our opinion that of all the health care reform plans currently under consideration in the Senate, President Clinton's plan will be the best for children and families since it builds and improves on our current system.

I hope you will find this report helpful as a measure for assuring that children do not get lost in the health care reform debate. It is our long-held position that health care reform for children must include, first, guaranteed financial access to health care; second, a comprehensive benefit package; third, access to the same class of care for all children, regardless of their parents' income, employment status or location, and insurance market reform such as guaranteed issue and reissue of health policies.

We believe that it is critical that health care reform include a mandated comprehensive benefit package that emphasizes prevention and primary care and spells out specific health benefits to address the unique needs of children. It is necessary that the benefits are specifically defined up front, because unless this is done, children may not get what they need.

Preventive care, the core of pediatrics, is poorly covered by most insurance policies despite their proven cost-effectiveness and medical efficacy. The Academy believes that preventive care is critical in any proposal designed to provide a healthier future for our children.

In any continuous, comprehensive benefit package that addresses children's needs, there must be a timely schedule for the delivery of these benefits and services. Such a schedule has been recently

developed by the Maternal and Child Health Bureau and the Health Care Financing Administration. It is entitled, "National Guidelines for Health Supervision of Infants, Children and Adolescents," and dubbed "Bright Futures." This is due out early next year.

We urge you to adopt the "Bright Futures" recommendation as a standard for children.

In addition, we must ensure that health care reform provides children with access to quality health care, and quality must be the touchstone, not necessarily cost. Special attention must be paid to caregivers with special pediatric training. We need to know, for example, that if a child is injured, that child will go to an emergency room that is properly equipped to handle the problem, or that a child with a congenital heart problem has access to a skilled pediatric cardiologist, or that when a child develops cancer, experienced pediatric oncologists will direct treatment to increase the chance for a cure.

Passage of health care reform that eliminates financial barriers to needed health care for many children will generate an increased demand for primary care physicians. These children and adolescents will need quality health care, the provision of which can be complex and time-consuming. We believe that pediatricians and other health care providers should provide this care for children, infants, and adolescents.

Presently, there is a national shortage and geographic maldistribution of pediatricians, the effects of which could be aggravated by health care reform. The Academy believes that there is a need for increased support for primary care specialties as a whole and for pediatrics in particular. To this end, we believe an incisive, short-term strategy must be accompanied by long-term incentives for medical students and residents to choose careers in primary care.

Today we are challenged with an historic opportunity reform our health care system. Providing all children and adolescents access to health care should be the foundation upon which meaningful reform is built, because health care reform for children is really about giving them a chance to reach their potential. If we can keep children well, they will have a fair shot at making the best of their lives, and that is all anyone can ask for.

We the pediatricians at the American Academy of Pediatrics look forward to working with this committee, the Congress, and the President as health care reform moves through the legislative process.

I thank you.

Senator DODD. Thank you very much.

[The prepared statement of Dr. Pearson follows:]

PREPARED STATEMENT OF DR. HOWARD PEARSON

Mr. Chairman, members of this distinguished Committee, I'm Howard Pearson, Immediate Past President of the American Academy of Pediatrics. I'm here today representing our 47,000 physician members, who are dedicated to the health of America's children.

I would like to speak briefly this morning about some of the problems children currently face in the health care system, and how those problems could be fixed under health care reform. With your permission, I would like to submit my written testimony for the record.

Mr. Chairman, you and members of this committee know well the issues confronting children and their families today. And let me state for the record that as I look at the members of this committee, in particular Senator Dodd, I would be hard pressed to find more committed advocates for children here in Congress. Senator Dodd, Senator Kennedy and members of this committee, the Academy is grateful for your work on child health issues. I'm proud to be at this hearing, the first on health care reform for children, because it marks a significant moment in the health care reform debate.

Children face many obstacles in the health care system, but one of the hardest to overcome is how most people view child health issues. They assume that in health care reform, what's good for adults is also good for children. The record suggests the contrary. The bedrock of the health care debate should be: as children go, so goes our country.

The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care, with an emphasis on prevention, is the single most important economic decision that will be made in the health care reform debate. As you write this legislation, you face a choice: deal with these problems while children are young, or America will pay ten-fold down the road. Morally, economically, medically, keeping children well and preventing illness makes sense.

But if that's true, then why do children have to struggle to become integrated in the current health care system? Why are children with relatively minor problems, like ear infections, showing up in emergency rooms with chronic problems? Why should children with cancer or other serious diseases be at risk because their parents lose their insurance coverage? Why young parents have trouble immunizing their children? I don't presume to know all of the answers to these questions, but I do know these problems seriously affect children and their families.

Through one of the many hats I wear as Medical Director of the Hole-In-The-Wall Gang Camp for children with cancer and blood diseases, I've seen first-hand the effect an illness like cancer has on families. Having a sick child is one of the toughest things parents have to deal with. Unfortunately, their anxiety is compounded by a health care system gone awry.

These same families have to fight with insurance companies—because insurance companies are too often making decisions about what, when and by whom their children will get care. These families work with pediatricians who are being crushed by an avalanche of paperwork and regulation. The Academy applauds President Clinton, the First Lady, and other Members of Congress who are working to put an end to this bureaucratic overkill, and enact comprehensive health care reform.

Another obstacle to overcome in this debate is how uninsured children are perceived. Most people think of the uninsured as somebody else's children. That's not entirely true. In 1991, of the approximately 12 million uninsured children, 58 percent were dependents of full-time, full-year workers. In essence, they are the children of the working class.

I know through your questions we will get down to discussing the details of the various proposals, and how they address these problems, so let me wind up by commenting on the Report Card on Health Care Reform for Children that you have before you. While we realize that the health care reform debate is very fluid right now, we thought it would be helpful to provide the committee with an independent snapshot of how children fare under various Senate health care reform plans. Although there are some significant and meaningful substantive improvements that need to be made, of all the health care reform plans currently under consideration, President Clinton's health care reform plan is the best for children.

I hope that you will use this report as a measure for assuring that children don't get lost in the health care reform debate. It's the Academy's long-held position that health care reform for children must include: a comprehensive benefit package; Access to the same class of care, regardless of their parent's income, employment status, or location; Guaranteed financial access to health care, and; insurance market reforms, such as guaranteed issue and re-issue.

It is critical that health care reform include a mandated, comprehensive benefit package that emphasizes prevention and primary care, and spells out specific health benefits that address the unique health care needs of children. If they are not specifically defined up front, children may not get appropriate benefits or even access. Preventive care, the core of pediatric medicine, currently is poorly covered by many insurance companies, despite the economic payback and medical efficacy of childhood immunizations, prenatal counseling and care, and screening for anomalies that may prevent or lessen lifetime disability when detected early. The Academy believes that preventive care is critical to any proposal designed to provide a healthier future for our children.

Also key to any continuous, comprehensive benefit package that addresses children's needs is a timely schedule for the delivery of those benefits and services. A schedule has been developed by the Maternal and Child Health Bureau and the Health Care Financing Administration titled "The National Guidelines for Health Supervision of Infants, Children and Adolescents" or "Bright Futures." It is due out early next year. This report examined the appropriate schedule of visits for children in greater detail than any other report, including the U.S. Preventive Services Task Force Report. The use of an age-appropriate schedule is critical to achieve the greatest value for the benefits provided. Anticipatory guidance visits, for example, can play a key role in avoiding injuries and disease, and detecting child abuse and neglect. The Academy strongly urges Congress to adopt the "Bright Futures" recommendations as the norm for children.

In addition, we must ensure that health care reform provides children access to quality health care, with specific attention paid to caregivers with special pediatric training. We need to know, for example, that if a child is injured, that child will be taken to an emergency room that is properly equipped to handle the problem. Or that a child with a heart problem has access to a pediatric cardiologist. Or when a child develops cancer, experienced pediatric oncologists direct the treatment to assure a real chance for a cure.

Passage of health care reform may eliminate financial barriers to needed health care for many children and generate an increase in demand for primary care physicians. These children and adolescents will need quality health care, the provision of which can be complex and time consuming. Pediatricians are the most appropriate providers of primary care for infants, children and adolescents. Presently there is a national shortage and geographic maldistribution of pediatricians, the effects of which could be aggravated by health care reform. The Academy believes that there is a need for increased support for primary care specialties as a whole, and pediatrics in particular. To this end, we believe a bold short term strategy must be accompanied by long term incentives for medical students, residents, and physicians to choose careers in primary care.

We are faced with a historic opportunity to reform our health care system. Providing all children and adolescents access to health care should be the foundation upon which meaningful health care reform will be built. Because health care reform for children is really about giving children a chance to reach their potential in life. If we can keep children well, they can have a fair shot at making the best of their lives, and that's all anybody can ask for.

The 47,000 pediatricians at the American Academy of Pediatrics earnestly look forward to working with the President, this committee and Congress as health care reform moves through the legislative process. Thank you.

REPORT CARD ON HEALTH CARE REFORM FOR CHILDREN

	BREAUX	CHAIKEE	CLINTON	GRAMM	WELLSTONE
Guarantees Coverage		✓+	✓+		✓+
Comprehensive Benefit Package	?	?	✓+		✓+
Age Appropriate Benefits	?	?	✓		✓
Strong Role for Public Health	✓		✓+		✓
One-Tier System			✓+		✓+
Insurance Market Reform(s)	✓+	✓+	✓+	✓	✓+
Pediatric Research			✓+		
Promotes Healthy Lifestyles	✓		✓+		✓
Children with Special Needs	?	?	✓		✓+
Mental Health		?	✓		✓+
Choice of Provider	?	?	✓+		✓+
Expands Pediatric Workforce	✓+	✓+	✓+		✓+

KEY:

✓+ = Good ✓ = Makes an effort ? = Incomplete Blank = Same as or no better than the current system

Senator DODD. I would mention—and I meant to mention it when the last panel was up—the issue was raised as to whether or not under President Clinton's proposal, we would get the kind of emphasis on preventive care—not that testimony is necessarily the only criterion on which we would rely. But I thought it was revealing that last week, when we had representatives from the Alliance for Managed Competition in, a nurse from CIGNA spoke at great length, in fact she is their director of preventive care. She talked about some of the very creative and worthwhile things they were doing in that area, and it is something we want to watch very carefully.

So the assumption that managed competition will not take into consideration effectively preventive care, I do not think holds up, but obviously we want to watch it very carefully.

Mr. Pearson. I think that is right. And I again would refer you, Senator, to the "Bright Futures" schedule, because in each of those visits, the specific issues that should be addressed from a prevention point of view and an anticipatory point of view are clearly defined. It is a remarkable document and one we will arm our medical students with and our residents as they go into their clinics.

Senator DODD. Well, I am glad to hear you say that. That may be more important than whether or not we get enough Congressmen and Senators to agree with us here.

Dr. Halfon.

Dr. HALFON. Thank you, Senator Dodd.

I am a pediatrician at UCLA in the Department of Pediatrics in the School of Public Health. I have also been working for the last year with a group called the Child Health Consortium, which is a group of independent child policy experts from different universities, research institutes, and consulting groups across the country that have been working on the health care reform piece. And I want to thank you for allowing me to address you today, also.

Health care reform, as everybody today has talked about, represents an extraordinary opportunity to improve the health and development of the Nation's children. And the three points that I want to make, just to echo, is that children are different and have different health care needs. This is especially true for children who are high-risk and particularly vulnerable, those kids who have chronic medical conditions like the ones that we were talking about on the first panel; children who are in foster care; children who are born to teenage mothers; children who are homeless; children who are abused and neglected. And their special needs need to be accounted for.

In thinking about special consideration for children, I want to make it very clear that we should do this on the basis of equity because unless we think about children differently, we will not treat them equally, and I think that that is something that we can argue very effectively.

But I think we also want to make that argument in terms of effectiveness and efficiency, because we all know that the reason why we are going through health care reform is because we are trying to make a more effective and efficient system, and to justify expanding eligibility for children, expanding benefits, reorganizing

the delivery system really means providing more effective and efficient services for children who really need them.

Getting all kids into the system and providing them with a comprehensive benefit package will allow us to really provide prevention and do the kinds of early intervention that we all know needs to be done.

It will also provide for allowing us to have cross-system savings. I want to make this point, that oftentimes as this health care debate will unfold, you will be talking about this benefit and that benefit and whether it is actuarially sound and if it is going to cost an extra million here or two million there. But we need to look beyond the health care system in terms of where the potential savings will come. We now have huge numbers of children entering the child welfare system; we have lots of children entering special education in the juvenile justice system and decreased economic productivity. And it is only here within the Congress that you can take the broad view and not take just the tunnel vision in terms of what health care reform means, but take a broad view by providing better preventive services to children, that we can save in these other systems.

The third point I want to make is that a child's standard of coverage is key in this bill; that by actually putting in a child's standard of coverage into the bill, we can use this as a way of really making sure that we have an equitable system, an effective system, and an efficient system, and that a child's standard of coverage could serve as an organizing principle for the whole health care reform movement.

Let me just elaborate briefly on each one of these points. At the present time, what is driving health care reform is cost and saving cost, health security for the middle class, and basically controlling the health care system. We are not really doing health care reform, and we should not be fooling ourselves, to improve access for children. That is not what is driving this process, and I applaud you for having this kind of hearing so that kids can be included. But the main train that is going down the track is being driven by cost and security, and kids are sort of dangling off the caboose way at the end of this train, and I think they need to be brought into the major focus of the health care reform process.

How will we do that? How will we bring kids in? One way of doing that is by demanding that there is universal eligibility for all children. Another way of making sure that children are accounted for is that the benefit package that is developed is actually a benefit package that meets the needs of children. The Academy and other child-related organizations have made suggestions in this regard, but I think it should be very clear that at the current time, the appropriate range of child and adolescent benefits are not consistently available in most private health insurance plans. While health maintenance organizations provide routine clinical preventive services for children, such as immunization, vision and hearing screens, few offer preventive services for high-risk groups of children.

HMOs are in the business of providing preventive services to keep kids out of the hospital, but they do not provide preventive services that are in the mental health area and the developmental

area and the other areas that are not going to cost them money down the line. There are no incentives for them to do that, and the kind of preventive services that Dr. Brazelton was talking about, the kind of early intervention services, are not routinely provided by HMOs at the present time.

Most PPOs and conventional indemnity plans do not even provide for routine preventive care, and under almost all privately insured plans, the long-term care plans that are provided are not those that are developed for children; they are actually adult long-term care plans that have been adopted for children.

So that if we are going to take care of kids, the benefit package has to be fashioned in such a way that really takes in kids' unique needs. The Health Security Act that the President has proposed goes a long way in that regard, but I will say that there are several areas in that Act that do not really address the needs of high-risk children. There are certain benefits that need to be included, especially developmental benefits, rehabilitative benefits, different kinds of speech and language therapy kinds of things.

As has been pointed out, the Health Security Act might provide at the present time for a child with a cleft lip and palate to have the surgery for the cleft lip and palate, but will not provide for the kind of speech therapy that that child needs to actually learn how to talk. We have to think about the special needs of kids.

An important point I want to make also is about the delivery system. We can have the best benefit package in the world, with everything written down, but if the delivery system is not there to provide those benefits, it is not going to do anybody any good. That has to do with both the private side, where discretionary decision-making is made in a lot of mediocre HMOs where doctors are forced to call a 1-800 "Mother, may I?" number to authorize the provision of a service that they know needs to be provided and causes all kinds of delays in getting people services, to the kinds of incredible fragmentations that exist within our publicly financed delivery system, where basically, the mothers and children that I take care of need a degree in social work and in civil engineering just to be able to find their way through the system to get what they need. And I am tired of seeing really hard-working families having to struggle so hard to make it through four or five bureaucracies in order to get what they need.

The same thing on the side of the physician. I train physicians, and I am working with both the Academy and the Ambulatory Pediatric Association on curricula to train physicians to take care of underserved populations. They are very frustrated with the inability to do what they know needs to be done for these families because the delivery systems are so set up that it works against them at almost every turn. And unless we deal with the quagmire of the delivery system, and not focus just individually on benefits, because it is not just in the benefits but in the delivery system, we will be a long way from where we need to be.

The other point that I want to make is that we also need quality assessment systems that are specific for children. Children are very different from adults. Adults have high-prevalence, high-morbidity, high-tech conditions. So that we can look at quality that has to do with whether someone lives or dies after they have their carotid ar-

teries reamed out, or have their gall bladder taken care of, but children have a lot of high-prevalence, low-morbidity, low-tech conditions, and it makes it much more difficult to determine what the quality of care is. And we have not done an adequate job of developing quality assessment measures for children or developing the systems that need to be placed under managed care or managed competition.

There is a big presumption there that we are going to have all these wonderful quality assessment systems and report cards that can report on all of these things. This might be the case for adults, but we do not have those for children.

Last, we need special safeguards for both legal and procedural issues for children, because children's health care, again, is different.

My last point—and I know the red light is on already—is that in the Stanford Law and Policy Review this month, Jameson and Weir have argued for a child standard of coverage. And this standard of coverage would require health plans to offer special services to children, and would also provide the tools for making sure that this would take place.

I think that the child standard of coverage is something that you need to think about very carefully. What a child standard of coverage would do is allow for ensuring the fairness that children's differences are recognized, and are recognized in all aspects of the health care plan, therefore ensuring fairness and equity so that they get the specialized treatments they need and the kinds of services they need.

A child standard of coverage could also be used as an organizing principle for health care reform so that benefits, both scope, intensity and duration, were guided by this child standard so that young patients got the appropriate degree of access to appropriate services, provided by an appropriate practitioner, pediatric specialist, in an appropriate setting, in the Centers of Excellence and pediatric teaching hospitals and in special clinics that take care of high-risk kids.

It could also be used to mold the delivery system, and I think you are going to need something to mold the delivery system that can say this is a child's standard; we are not wanting all kids to fit into the same model of care that takes care of healthy adults, because one kind of managed care system is not going to take care of everybody.

It would also allow you to say that we need different quality assessment procedures for children and allow for you to say we need different safeguards for children.

It would also allow you to do one other important thing. Sprinkled throughout the Act is the notion of "medical necessity." Sprinkled throughout the Medicaid legislation is the issue of medical necessity. Medical necessity is increasingly being used as a way of keeping people out of services, and unless we have a child standard as an instrumental concept within the Act, we will not have the wherewithal to say this needs to be provided because it is necessary for children, because children are different, and they need a different kind of care.

So I would invite you to look at the Jameson and Weir article that lays out in much greater detail what should be done in term's

of a child standard, and to think about the possibilities in which it could be used to mold the health care reform package.

I would like to commend the President and Mrs. Clinton for the leadership that they have taken in developing the Health Security Act and this committee for specifically looking at the issues that have to do with children.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Halfon follows:]

PREPARED STATEMENT OF DR. NEAL HALFON

Senator Kennedy, Senator Dodd, and members of the Labor Committee, I am Dr. Neal Halfon, Associate Professor of Pediatrics and Public Health at UCLA, Co-director of the Maternal Child Health Policy Research Center, Consultant at the RAND Corporation, and a member of a number of committees and advisory groups that focus on the health care needs of vulnerable children. My clinical practice and research has revolved around the health care needs of children with chronic illnesses and debilitating conditions, specifically children who have been abused, neglected or placed into foster care. I have worked for the last year with the Child Health Consortium, a group of independent child health policy experts from different universities, research centers and consulting groups across the nation that came together to assess how health care reform can be organized and implemented to best meet the needs of children and their families. Thank you for allowing me to address you this morning and share my experience and concerns about children with special health care needs due to either biological or environmental risks.

The Promise of Health Care Reform

Health care reform represents an extraordinary opportunity to improve the health and development of the nation's children. While all children are potentially vulnerable, there are groups of children with more extensive needs that demand wider range of health benefits, and customized delivery systems. These children include those who have chronic and debilitating medical, and mental health conditions, children who are abused, neglected, and/or placed in foster care, children born to families that are compromised due to mental illness or substance abuse, children born to teen-age mothers, and children whose families are homeless.

Society's Interest and the Special Needs of Children

Society has an unusually strong economic and moral interests in ensuring that children grow into productive adults, and in providing the basic services they need to do so. However, the particular developmental vulnerability and dependency needs of children means that ensuring comparable access to appropriate services may require that children receive different treatment than adults. Congress and the Supreme Court have provided legislature and doctrinal bases for a statutory standard that would accommodate the special needs of children and ensure they receive the resources they need.

In *Sullivan vs. Zebley*, and in *Plyer vs. Doe*, the Supreme Court upheld the provision of benefits to children based on the recognition of the importance of health and education benefits to childhood development. In *Zebley*, the court enforced the congressional mandate that children's access to disability benefits, including eligibility to Medicaid, be comparable to adults, thus accommodating the fundamental difference between the health needs of children and adults. In the 1967 amendment to Medicaid, Congress created the Early Periodic Screening Diagnosis and Treatment (EPSDT) program to provide financing for special preventive and treatment service for children under 21 years of age. Thus, Congress created a special benefit program for children in order to prevent harm and promote health. Both of these precedents acknowledge that to guarantee comparable treatment of children and adults requires accommodation of their recognized differences.

The Challenge of Vulnerable Children With Special Health Care Needs

Addressing the special health care needs of vulnerable children is particularly challenging because the number of children with special health care needs continues to increase, while the condition facing many young families continue to deteriorate. A related challenge of health care reform is to replace the patchwork of under-funded, fragmented, and difficult to navigate, health programs that frustrate the most committed families and providers with a more rational delivery system. None of the health reform proposals that have been put forth specifically address the needs of high risk children, nor do they address how the current patch work of child health programs could be integrated into a coherent, effective, and efficient system of care. While the mismatch between the needs of vulnerable children and families, and the current service delivery system is extreme and growing, the lack of a coherent vision of how to integrate the service needs of these children and families into the center of the health care reform process, could result in continued marginalization of these children, and could possibly diminish available benefits and service delivery capacity as a result of health care reform.

The remainder of this statement will highlight:

1. The nature of the current mismatch;
2. How health care reform must address basic eligibility, benefit, delivery system, accountability and safeguard issues, and;

3. How a child standard of coverage should be included in any reform package to guide reform and assure that the needs of children are adequately addressed.

The population of high risk children in the US. is growing:

- In 1989, 5% or 3.4 million children suffered functional limitations due to a chronic condition, having increased steadily from about 2% of the child population in the 1960's.¹ Of those children 62% are privately insured, 24% receive Medicaid, 4% are covered by other government programs, and 15% are uninsured. Only three out of five disabled children living in poverty are covered by Medicaid. Many disabled children are unable to qualify for private health insurance coverage due to pre-existing condition exclusions.
- The Institute of Medicine has estimated that 12% of all children and youth have diagnosable mental health problems, and data from the 1988 National Health Interview Survey on Child Health indicates that 20 percent of children less than 18 years of age have learning, emotional and behavioral problems.² Only one in five children who need mental health treatment, and less than one in eight adolescents who need alcohol or drug abuse treatment receive it³.
- In the wake of escalating and persistent poverty, family violence, mental illness, and the drug epidemic, the number of reports of child abuse and neglect surpassed 2.4 million in 1988, and continues to rise. The numbers of children placed in foster care is also increasing with estimated 460,000 children in foster care in FY 93, with more than 659,000 served by the system that year. Approximately 60% of the children in foster care have moderate to severe mental health and behavioral problems and 40% have chronic medical conditions that demand ongoing treatments.
- The number of children born to teen age mothers, and the numbers that are drug exposed in-utero, also continues to increase.
- Further manifestations of the mismatch between needs and services include: the 50% or more of children that do not receive timely immunization by age 24; the 3% of all children that routinely use emergency rooms for sick care because of lack of available primary care providers⁴; the poor continuity of care for many children who receive well child care in community clinics⁵; the increasing rates of children being hospitalized for childhood asthma, with poor children demonstrating 40% more hospitalizations and 40% fewer outpatient visits⁶
- The financial implications of the concentration of morbidity in relatively small number of children with multiple needs is illustrated by the fact that in 1987, one percent of children account for 37% personal health care expenditures for children less than 18 years of age, and that 5% of children account for 59% of expenditures.⁸ For example, in California even though children in foster care represent only 4% of the child population covered by Medicaid, they account for over 40% of what the state Medicaid programs spends on mental health services for children.⁹

Vulnerable Children Need a Broad Array of Complex Health Services

Children with chronic illnesses, children in foster care, children born to teen age mothers, and other high risk groups of children, require a broad range of health care services. Given the high level of need, these children require access to full range of

preventive, primary care, specialty, and rehabilitative services. The process of delivering appropriate care to these children and families is complex, and efficient delivery often demands the co-location of several providers, the use of multidisciplinary teams, and additional case management and coordination services.

For example: Johnny is a little boy with a cleft lip and palate. He will require at least two surgeries, special monitoring for potential ear infections, speech and language therapy. A single center that can provide all of these services, improves efficiency and effectiveness.

Dehynn is a four year old girl who has been in foster care since she was two, and is now in her fourth foster home. Dehynn suffers from asthma, eczema, an allergic skin condition, language delay, depression, and a sleep disorder. Before coming to a special health center for children in foster care her foster mother was unable to organize all of her care.

Children and Families Encounter Financial and Delivery System Barriers

At the present time there are numerous barriers to the receipt of appropriate care. Many children are not insured and have no way of becoming insured. Children on Medicaid can face delays in establishing eligibility, or live in states where Medicaid reimbursement is so low that providers will not provide services. Significant barriers are posed by the current fragmented service delivery system with multiple programs, eligibility criteria, and locations of care. The combination of inadequate financial support and a poorly organized system results in children with chronic medical conditions that cannot get appropriate speech or rehabilitation services, children in foster care who cannot get mental health services, and infants of young teenage mothers who cannot receive developmental services. Improving the effectiveness and efficiency of the delivery system means having a full continuum of service available and organized in a delivery model that best meets the needs of the population. In some cases this means a regionalized center of excellence staffed by multidisciplinary teams of providers so that all services can be provided under one roof. Alternatively, it may mean, more decentralized, community-based, programs that include home based services for those families that are particularly hard to reach.

How Can Health Care Reform Improve Access, Effectiveness, and Efficiency of Health Services for Vulnerable Children?

Given the increasing numbers of children with multiple and special health care needs, and the inadequacies of the current system to provide access to an appropriate

range of effective services delivered in an efficient manner, health care reform must address the following five areas:

I. Eligibility- Universal coverage of all children should be guaranteed. If universal coverage is to be phased in, it should begin with children. Special eligibility considerations need to be addressed towards children who are in foster care or other out of home arrangements.

II. Benefits- Children's health needs are different from those of adults. While adult and child health care share common goals of prevention, diagnosis, and treatment of diseases and injury, children's health care is broader in scope and different in substance, due to the rapid growth and development that characterize childhood. While illness can cost an adult some degree of normal functioning, it can deprive a child of any chance to achieve normal functioning as an adult. Other important differences between children and adults include children's dependency on adults, and the different type and pattern of condition that are manifest in childhood, the different ways that illness is expressed, and the different ways that children respond to therapy. These developmental and dependency parameters make children uniquely vulnerable to illness and developmental disabilities, and require a continuum of services that are broad, and include appropriate preventive, primary, specialty, and long term care services provided by skilled professionals in pediatric care.

As the attached policy brief, written by my colleagues, Harriette Fox, and Margaret McManus highlights, an appropriate range of child and adolescent benefits are not consistently available in most private health insurance plans. While health maintenance organizations provide routine clinical preventive services for children, such as immunizations, and vision and hearing screens, few offer specialized preventive services for high risk groups, nor do HMOs routinely provide the recommended scope of specialty care. Many PPOs and conventional indemnity plans do not even provide for routine preventive care, and under almost all privately insured plans long-term care benefits have been exclusively designed for adults and not children. It should also be noted, that no matter how generous a benefit package is on paper, discretionary decision making procedures by a plan, can functionally limit the provision of services.

For example: Johnny, the boy with the cleft lip and palate may not get all of the services he needs. If Johnny's parent's benefit package does not

cover rehabilitation services then he would be covered for surgical repair of the cleft lip and palate but would not be eligible for speech therapy to help him learn to speak.

In order for national health care reform to address the needs vulnerable children, the basic benefit package must be comprehensive. The basic benefit package proposed in the President's Health Security Act comes close to meeting this goal and will probably serve a large percentage of the child population quite well. However, additional benefits are needed to ensure access, (such as transportation, care coordination, case management, and translation services), a full array of preventive services (e.g. developmental and behavioral assessments, home visitation with home based developmental and behavioral assessment for high risk infants and toddlers, etc.), developmental and habilitative services (e.g. diagnostic testing, physical therapy, speech therapy, occupational therapy, family counseling etc.) and long-term care services (see McManus and Fox, 1993).

For example: If Delynn, the little girl in foster care had received a comprehensive developmental assessment when she first came into foster care, her depression could have been recognized, therapy instituted, thereby averting some of the other behavioral problems that she has developed.

III. Delivery system-Making a full range of benefits work for children depends on the organization of the delivery system. Managed care has become a preferred way of organizing care because of the evidence that it efficiently produces and allocates services, and lowers costs, without impacting on health status. However most of these conclusions have been drawn from staff-model HMOs caring for relatively healthy middle class populations. Irrespective of the efficiencies demonstrated for relatively health populations, there is no evidence that managed care improves access, the delivery of appropriate preventive services, or the quality of services to children with special health care needs.

While the impact of current managed care arrangements on children with special health care needs is unknown, there is considerable reason to believe that the current configuration of managed care will not well serve many high risk children and families, since many of the basic premises and procedures are antithetical to the service delivery goals for children with special health care needs.¹⁰ Alternative models of managed care need to be developed for children with special health care needs. In Los Angeles we have

just begun on such a project called the Protective Services Child Health System, an alternative model of managed care for the 60,000 children in the child welfare system in Los Angeles.

Even if managed care systems could be expertly customized to meet the needs of high risk children, there will still be a wide range of necessary services provided outside of health care plans. For example children will still need to receive WIC, Comprehensive Child Development Center services, lead screening and abatement services, school based health services, special education services. There will be other public health functions related to immunization tracking, birth defects monitoring and counseling, that will need to be integrated into the system.

For example, Dehym, the 4 year old girl in foster care, might receive care in an excellent managed care plan, that has identified and begun treatment of her asthma, eczema, depression, language delay, and behavioral problems, but Dehym will need to receive some special service through a comprehensive child development center, and special education services at her local public school.

If we adopt a system organized through health alliances and accountable health plans, as proposed in the President's plan, private-public linkages will be necessary. For example, even if all health plans screen all children for lead exposure, and provide the primary case management to reduce risk of future exposures, specified linkage services through the alliance or a public health department will still be necessary for the provision of lead abatement services. Similarly, the health plan may conduct development and behavioral assessment on children, and provide case management and coordination services, but might have a linkage with a school to provide physical therapy, occupational therapy, special education and mental health services consistent with IDEA.

If a seamless continuum of services is to be provide to children such delivery system architecture and organization must be given high priority under health care reform. Attempts to streamline and integrate services will face significant barriers unless steps are taken to de-categorize programs, so that service systems can be more flexibly integrated.

IV. Quality of Care—Quality of care information is particularly of concern for health care reform strategies that rely on capitated managed care plans, because those organizations have incentives to limit access to health care services in order to cut costs. Although

under-use is the main quality concern under managed care, there are other concerns about the appropriateness of certain services on both an individual and plan-wide basis.

There has been little research and even less development of quality assessment measures for children. As is the case for benefits and delivery system issues children have unique quality assessment needs based on the prevalence, pattern and manifestation of diseases. As opposed to adults who have high prevalence, high morbidity, and technologically intensive conditions, children either have high prevalence, low morbidity, and less technology-dependent conditions or low prevalence, high morbidity, and technology intensive conditions. These differences in the prevalence and patterns of conditions raise several technical measurement problems for measuring quality of care. For example, in any one health plan, there will not be a sufficient number of children with diabetes to determine whether the technical quality of care was appropriate. Furthermore, for common, low tech, conditions like asthma or ear infections, judging the quality of care is difficult.

If health care plans are to compete on the basis of quality, rather than simply on price, reliable quality of care information is necessary. Quality of care information is needed by alliances to know which plans to offer, by consumers so that they can make informed choices between options, and by providers so that they can improve their abilities to provide medically-appropriate care. The lack of attention to quality standards, measures, and systems for children is particularly problematic given needs for alliance to meet federally established premium targets and the desire of plans to see a reasonable profits.

Pediatric practice guidelines and quality assessment procedures need to be developed so that they are available as the health care system begins to change. Measures must be developed that assess both the process, and the outcomes of care, that include both technologically intensive medical conditions, and behavioral, developmental and emotional conditions. Steps must also be taken to provide incentive to alliances and plans to improve the quality of care provided to children. These steps will require commitment and investment on the part of the federal government to assure that systems are developed, and that different incentive strategies are tested.

V. Safeguards-Adequate legal and procedural safeguards must be provided in the plan so that children and families have recourse to remedies when they are unfairly treated by a

provider, plan, or alliance. Children with special health care needs are particularly at risk for denial of services, especially when such services are urgent, or highly specialized, or costly. While the Constitution requires due-process whenever a benefit is delayed, denied or terminated in a public program, similar due process considerations are not in place under private health insurance plans. At the present time some 6 bodies of statutory and common law doctrine regulate the provision of private health insurance, and because the organization of care has changed so much over the past ten years, these overlapping legal doctrines do not present a coherent set of protection of any beneficiary, including children. Several of the legal doctrines, in fact, have inherent characteristics that preclude the development of standards.¹¹ For example, ERISA provisions limits beneficiaries in self-insured plans for holding plans accountable for denials of certain health benefits.

Child Standard of Coverage

In an article published this month in the *Stanford Law and Policy Review*,¹² Jameson and Wehr argue that health reform legislation should require, employment-based group health plans to meet a separate standard of coverage for children. They contend that the prevailing adult, acute-care model of coverage inappropriately limits preventive and other types of service that are important to children because of their unique characteristic as patients. These characteristics include children's developmental vulnerabilities, their dependence on adults, and the idiosyncratic incidence and expression of their disorders.

Jameson and Wehr suggest that a children's standard of coverage would have two parts. First, reform legislation should require health plans to offer specific health care services for children. Second, it should require the plans to use the clinical values of pediatric health care to determine the amount, scope, and duration of these services for children. Jameson and Wehr also argue that for a children's standard of coverage to be effective legislation must provide the legal tools for assuring compliance with the standard including a *private right of action* that would allow individuals to hold plans, and the entities that regulate them, accountable for meeting the standard of children's coverage; that legislation authorize damage awards exceeding the actual cost of an inappropriately denied service; and that judicial review of questionable health-plan restrictions or denials of benefits be permitted *de novo*.

As a non-lawyer I find the argument for a child standard of coverage very compelling. The standard of coverage proposed by the authors has wider applicability

than would a standard of care, (which are the technical standards set by professional organizations like the American Academy of Pediatrics and the American College of Physicians), or alternatively a standard of benefits, (which would be limited to the basket of benefits provided to children by any one plan).

While pediatricians and other child health providers take for granted that children are not just little adults, with unique health needs arising in their developmental vulnerability and the degree to which they depend on their parents and other social and governmental institutions, this special status of children is not adequately reflected in the debate about health care reform.

The President's Health Security Act requires health plans to offer such pediatric benefits as immunizations and well-child care, as well rehabilitative, home-care and other services of special importance to children. But children's actual access to many of the required services is now and would continue to be controlled by administrative practices of managed-care plans that effectively restrict the amount, scope and/or duration of offered services. Except for the proposed continuation of the Medicaid EPSDT standard, for impoverished children only, the Health Security Act lacks a child-specific rule that would require plans to use *pediatric* clinical values with regard to appropriate access for children to certain mandated services. Moreover, because the EPSDT standard is limited to poor children covered by Medicaid, it cannot be a generalizeable principle for health reform. Yet such a principle is needed to assure, for instance, the existence of appropriate health-delivery systems or quality assessment systems for children.

By developing and using a children's standard of coverage, four important goals can be accomplished: 1) ensure fairness (equity); 2) serve as an important organizing principal for systemic health reform; 3) shield the health interests of children from interpretations of "medical necessity" that inappropriately deny them medically indicated care; 4) make remedial actions more effective for children.

1. **Ensuring fairness** - Building on the Supreme Court decision in the Zebley case the child standard of coverage would mean that children's health needs must be determined in a way that takes into account children's developmental and dependency needs, and their needs for specialized diagnostic, treatment and medical management skills.

Making explicit and addressing these differences between children and adults as patients should result in fairer treatment of children than under current adult models of coverage.

2. Serving as an organizing principle for the health care reform proposal - A child's standard of coverage has implications for improving the effectiveness, appropriateness, and allocative efficiency of services provided to children as part of the Health Security Act.

- **A. Benefits** - *The scope, intensity, and duration of benefits:* the unique developmental and dependency characteristics of children require that benefits for them be broader in scope, and in certain instances, of greater intensity and longer duration, for healthy growth and development. A child standard should assure young patients an appropriate degree of access to appropriate services (i.e. habilitative, rehabilitative, case management benefits, etc.) provided by an appropriate practitioner (i.e. pediatrics specialist) in an appropriate setting (i.e. centers of excellence for child health), when required by a child's condition.
- **B. Delivery System** - The health care delivery system must be organized to respond efficiently to the developmental and dependency characteristics of children. A child standard would help justify the inclusion of children's hospitals, and other centers of excellence, both for technical medical procedures, (i.e. pediatric cardiovascular surgery or child cancer centers), and for special regionalized services, such as, centers for child abuse, foster care, etc. that integrate health with social and other supportive services that are required by children's dependent status. Thus, a child standard would improve allocative efficiency of the system.
- **C. Quality assessment** - The unique developmental characteristics of children as well as the distribution of morbidity in the child population poses particular technical difficulties in the development of quality assessment systems. A child standard of coverage should be used to design appropriate quality, measures, and assessment systems.
- **D. Safeguards** - The special development and dependency characteristics of children necessitate standards of care that are sensitive to medically relevant differences in developmental status for a given condition, e.g. asthma care in the infant vs. asthma care in the teen. A standard of coverage must also be responsive to the child-specific needs that cannot be articulated by the patient and may not be recognized by or effectively asserted by a patient's parents.

3. Defining medical necessity - A child standard of coverage will help prevent determinations of "medical necessity" that inappropriately limit or deny access to services that are medically indicated for a child (but may be of lesser importance for an

adult). The instrumental concept of medical necessity has been transformed over the past ten years from a doctor-determined judgment with regard to an individual patient to a plan/system-determined principle for a class or population of patients in managed care. Medical necessity in this context refers not only to clinical values but also to the legal authority for limiting patient access to services. A child's standard of coverage would ensure that medical necessity is interpreted in a way that is not hostile to children's distinctive health profile.

4. **Permitting remedial action** - Having a child standard of coverage included in the Health Security Act, would supply the appropriate standard for use in remedial actions against plans and alliances or regulatory agencies on behalf of a child or class of children who are not receiving *appropriate services from appropriate providers in the appropriate delivery system.*

I would like to commend the President and Mrs. Clinton for the leadership that they have taken in developing the Health Security Act, and their commitment to the needs of children. The inclusion of a child standard of coverage in the Act could ensure that the Act accomplishes the goals that the President has set forth in his call for health care reform for the nation.

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⁹Halfon N, Berkovitz G, Klee L Mental Health Service Utilization by Children in Foster Care in California. *Pediatrics*, 1992; 89:1238-1244.

¹⁰Freund DA, Lewitt EM Managed Care for Children and Pregnant Women: Promises and Pitfalls. *The Future of Children*, 1993; 3:92-122; Hughes D, Newacheck PW, Stoddard J, Halfon N. Medical Managed Care and Children's Health, submitted *J Health Policy, Politics, Law*, October 1993.

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Senator DODD. Thank you very much. Those are some great suggestions, and we will look at the Jameson and Weir study. You have raised some excellent, excellent points.

Just to highlight what you are saying, I have tried for a week to add a new dimension to the crime bill that we are debating, and it may happen today. There is \$23 billion that, all of a sudden, we have discovered we have got someplace. And one of the big issues in the debate, one of the target constituencies is kids, the victims as well as the people involved in it.

I came up with the idea of "an ounce of prevention." My idea is to just get an ounce of prevention, one-sixteenth of the bill, for prevention. Well, I am not going to get one-sixteenth, but I have now got it up to around \$500 million for youth violence, just in prevention in that area—and you would think I was trying to steal money and dump it someplace that does not make a difference.

Here, we have terrific organizations—many of them nongovernmental, by the way—around the country that are doing an excellent job. The difficulty, answering your question of why do we have such a hard time, which is my question as well, is that statistically, it is hard to prove what does not show up someplace. When someone is well, we do not chart that. We can tell you how many kids have measles, how many have mumps, how many have rubella, how many kids are victims of gunshot wounds, how many are in jail. But statistically, we have a hard time telling you how many kids we have kept out of jail this year; how many did not get shot in some high-risk neighborhood. So it just does not lend itself to what most politicians and people love, and that is to give statistical speeches about what a terrible problem we have, and look at the numbers.

So it is an ongoing and very frustrating issue to get people to focus on how much money you can save with an ounce of prevention approach.

We have some systems set up—and I will not bore you with it—which we think are going to help cut through a lot of the bureaucracy and so forth and start getting some of these dollars back.

Your testimony has been very helpful.

Dr. Anderson.

Dr. ANDERSON. Mr. Chairman, committee staff, fellow panelists, I am Larry Anderson, a family physician from Wellington, KS and a member of the American Academy of Family Physicians.

As a rural family physician, it is a privilege to represent my colleagues and my patients as we meet here this afternoon to consider reform of our current health care system, a system which is failing, a system which day by day makes it more difficult to provide health care to the rural citizens of this country, especially maternal and child health care, which is the focus of this discussion.

There are three key issues that we must address if we are to provide adequate health care to rural populations. We must, first, have universal access to and coverage for comprehensive health care services. We must, second, train more family physicians. And we must, third, have professional liability reform.

My partner and I live and practice in the number one wheat-producing county in this Nation. The county has a stable population of 28,000, and in 1976 when we started practice, we had 19 doctors

living in the country and serving as residents. Through death, relocation and retirement, those 19 physicians have decreased to 9, with only 5 of us still delivering babies.

Joel and I deliver about 80 babies a year, and we do our own C-sections. Every day, we deal with the miracles of conception, human development, labor and delivery, illness and disease, recovery and rehabilitation, and the dignity of death and dying. We provide true cradle-to-grave care for our patients.

As you know, rural populations have higher-than-average percentages of elderly individuals, which means more Medicare patients. Rural communities have higher rates of unemployment or underemployment, which means more Medicaid patients, or no insurance at all.

I will shortly have the privilege of assisting a young mother with the delivery of her third child. I have yet to receive payment for delivering her first two children. This family is a typical one—nice, good young parents, and rural, but trapped in the predicament of the working poor.

Like most rural family physicians, I do not worry that much about my low fee schedule. I worry about getting paid at all.

I am not going to list horror stories of instances where individuals were injured because they did not receive care, because that really does not happen in my county. If a patient seeks health care, every doctor in my county will see that patient and will continue to provide needed care whether we get paid or not.

However, there is a problem developing in my county regarding access to obstetrical care. Professional liability expenses have forced the doctor in the southwest corner of my county, and all doctors in the county to the west, to give up their ob practices. This situation leaves an area of 2,000 square miles without easily available ob care. It will only be a matter of time before the distance that expectant mothers have to travel will result in damage to an infant or a mother.

Patients sometimes drive over 50 miles one-way from that county to my office for ob services. Many of these expectant mothers do have insurance, usually Medicaid, and all are willing to make the trip to my office, if that day, they have gas money and a car that runs.

Other panelists have discussed specific cases of infants needing specialized health care. Readily available prenatal care will improve obstetrical outcomes, but special children with special needs will still be present in any future health care system. Their care will be provided for the most part by pediatric subspecialists located in tertiary care facilities, not in rural facilities, in cooperation with local primary care physicians, be they pediatrician or family physician.

The fact, however, is that pediatricians and obstetricians rarely locate in rural communities. Family physicians are the only doctors adequately trained to provide the broad scope of care demanded by rural practice. Because of low population densities, diverse health care needs, and fiscal constraints, family physicians are usually the only specialty that a rural community can support.

Our current health care system contains many disincentives against careers in primary care and especially in family practice,

including low prestige, hard work and poor pay. Senator Kassebaum's office is aware of a 1987 Kansas Farm Bureau study documenting that rural physicians work more hours, see more patients, and make less money than do their urban colleagues. Rural health care in Kansas today is more bleak than it was 6 years ago when that study was completed.

Most young medical students are idealistic, but very few want to be missionaries, and most now view rural practice as mission work. If we are serious about providing quality care, especially quality ob and prenatal care, to our rural populations, we must have universal access, train more family physicians, provide professional liability reform. We must develop a reimbursement system that encourages young physicians to move to rural communities where their services are so greatly needed.

I appreciate this opportunity to speak and look forward to your questions.

Thank you.

Senator DODD. Thank you very much, Dr. Anderson; excellent testimony. I will have some questions for you in a minute.

[The prepared statement of Dr. Anderson follows:]

PREPARED STATEMENT OF DR. LARRY ANDERSON

Mr. *Chairman*, Committee members and fellow panelists, I am Larry Anderson, MD. As a rural family physician, it is a privilege to represent my colleagues and patients as we meet this morning to consider reform of our current health care system, a system that is failing. We have currently a system that day-by-day makes it more difficult to provide health care to the rural citizens of this country, especially maternal and child health care, which is the focus of this discussion.

There are three key issues in health system reform that must be addressed if we are to provide adequate health care to our rural populations. We must have:

- 1) Universal access to comprehensive health care services,
- 2) Training of more family physicians, and
- 3) Professional liability reform.

I will begin by outlining the problem and describe these solutions at the conclusion of my statement.

Background

My partner and I live and practice in the number-one wheat-producing county in the nation. It is a county in Kansas that has a stable population of 27,000 and which in 1976 had 19 doctors living in the county and serving its residents.

Through death and retirement, the number of physicians has decreased from 19 to nine, and only five of us still deliver babies. The state of Kansas has certified our county as "critically underserved."

My partner, Joel, and I deliver an average of 80-100 babies a year and perform our own C-sections. Our practice had 26,000 office visits in 1992. I am the

county coroner, medical director of three nursing homes, and director for two county ambulance services. Each day, we deal with the miracles of conception, human development, labor and delivery, illness and disease, recovery and rehabilitation, and death and dying. We provide true "cradle to grave" care for our patients.

Rural populations have higher than average percentages of elderly individuals (33% compared to 25% percent of the general population), which means more Medicare patients. We have also higher rates of unemployment or underemployment, which means more Medicaid patients and those with no insurance at all. I estimate that about 20% of the patients in my practice are uninsured. Rural America has also disproportionately high infant, fetal and maternal mortality rates, due, in part, to lack of obstetrical services and lack of access to primary care.

Obstetrical Issues

In the very near future, I will have the privilege of assisting a young mother with the delivery of her third child. I have yet to receive payment for delivering her first two children. This family is a typical one -- nice, young, and rural, but trapped in the predicament of the "working poor." Like most rural family physicians, I worry not only about reimbursement rates, I worry also about getting paid at all.

There is, however, a problem developing in my county regarding access to obstetrical care. Professional liability expenses have forced the doctors in the southwest corner of our county and those in the neighboring county to the west to give up their OB practice. This situation leaves an area of 2,000 square miles without readily available OB care. It will be only a matter of time before the distance that expectant mothers have to travel to receive obstetrical care results in injury to an infant or mother.

Patients now have to drive over 50 miles, one-way, from the neighboring county to my office for OB services. Many of these expectant mothers do have insurance, usually Medicaid insurance, and all are willing to make the trip to my office if they have gas money and a car that is running that day.

Child Health Issues

Other panelists have discussed specific cases of infants needing specialized health care. Special children with special needs will be present in any future health care system. Their care will be provided, for the most part, by pediatric subspecialists located in tertiary care facilities, in cooperation with a primary care physician. The primary care doctor may be a pediatrician or a family physician.

In my practice, children with very complex medical needs are referred to a Wichita medical center, which is about 35 miles away. Family physicians, like myself, however, are trained to take care of 85-90% of the problems we see every day, and that includes all but the very sickest children.

Rural Health Care Networks

I am delighted to see that President Clinton's health care reform plan includes strategies for network formation that encourage local community involvement in health care planning and development efforts. The essential community provider requirements will help ensure that local delivery systems remain intact. Grants to stimulate and support the development of networks in medically underserved areas, and loans to provide much needed capital, will help with the transition to a system in which medically-underserved populations have more certain access to community-oriented providers and health care plans.

The plan's support for projects linking rural providers with each other and with regional health care institutions and academic health centers through telecommunication systems is vitally important to sustaining rural health systems. Fostering regular referral relationships will not only help to improve the timeliness of care available to rural residents at the referral center, but will help ensure continuity and follow-up when they return to their own communities.

In many instances, the rural telemedicine networks described in the proposal will reduce the need for long-distance referrals, as top notch expertise will be made available to rural residents right in their local hospitals and physicians' offices. One important side-effect of these linkages will be to reduce the flow of local patient care revenues to urban referral centers.

Physician Distribution in Rural Areas

Pediatricians and obstetrician-gynecologists locate rarely in rural communities. Only ten percent of ob-gyns and nine percent of pediatricians practice in rural areas, while the comparable number for family physicians is 24 percent. Family physicians are the only doctors trained adequately to provide the comprehensive scope of care demanded by rural practice. The *Third Report of the Council on Graduate Medical Education* states that "problems of access to medical care persist in rural and inner-city areas despite large increases in the number of physicians nationally."

Family physicians are also the only specialty to locate in rural areas in the same proportion as the general population. Rural population health care needs and fiscal restraints will not usually support any other specialty physician group than family physicians in rural practice. According to the Office of Technology Assessment report, *Health Care in Rural America*, family physicians need only

3,000-4,000 residents to support a practice, compared to 11,000 residents for obstetrician-gynecologists.

I am not going to list horror stories of instances where individuals were injured because they did not receive care, because that has not happened yet in my county. If a patient seeks health care, every doctor in my county will see that patient and will continue to provide needed care whether he or she is paid or not. But, as the number of rural physicians continues to decline, I am not sure that we will not have some horror stories to tell. I fear the first will be an expectant mother or her child.

Our current health system contains many structural disincentives against a career in family practice, including low prestige, hard work and poor pay. Senator Kassebaum's office is aware of a study done by the Kansas Farm Bureau, in 1987, which documented the fact that rural physicians work more hours, see more patients, and make less money than do their urban colleagues. Rural health care in Kansas in 1993 is even more bleak than six years ago when this study was completed. It is difficult to get young family doctors to locate in an area where payment is not guaranteed and you are on call every other night. Most young medical students are idealists, but very few want to be missionaries.

Possible Solutions

Universal Access to Comprehensive Health Care Services

Universal access to health care services would solve the problems associated with uninsured patients in my county; lack of primary and preventive care and lack of adequate payments to rural physicians like myself. In my county, we have tried for 15 years to bring in additional physicians. Frankly, most physicians see the low Medicare reimbursement as a hardship, but since this issue is not under the jurisdiction of this committee, I mention it only in passing.

More importantly, as I said earlier, young physicians are discouraged from locating in rural areas because they may never be paid for their health care services. Providing health insurance coverage for the 20% or so of my patients who are uninsured would improve their health care, as well as encourage physicians to practice in rural communities.

President Clinton's health care proposal guarantees universal coverage, which would be clearly beneficial to rural health care services.

On a related issue, we support the provisions contained in the Clinton plan regarding school-based clinics. It is our understanding that they are targeted toward medically underserved areas, which we believe is appropriate. The Academy also supports coordination of these programs with community-based providers, such as family physicians.

Training of Additional Family Physicians

In most developed countries at least 50 percent of physicians are generalists. In the U.S., the physician workforce is made up of more than 70 percent subspecialists and only 30 percent generalists. Family physicians/general practitioners make up only 13 percent of the total.

Creating an Appropriate Balance of Generalists and Subspecialists

The Clinton plan recognizes clearly the need to strengthen the availability of primary care. Family physicians view this as a structural change of fundamental importance to achieving real cost-containment and universal coverage. While much has been said in recent years about the shortage of generalist physicians, the rhetoric is often unmatched with action.

We are particularly pleased that the Clinton plan focuses attention on and identifies specific strategies for achieving a more appropriate balance of generalist and specialist physicians (Secs. 3031-3034). Physician workforce goals must reflect the health care needs of the population. Correcting the problems of specialty imbalance in the system will require significant changes in current federal policies and aggressive interventions. These efforts are controversial as they challenge the status quo, but they are essential if we are to achieve universal access to comprehensive health benefits.

We are supportive generally of the approach taken in the Clinton plan to allocate residency slots through a national commission. Graduate medical education funding should be in accordance with national goals relative to the distribution of primary care and non-primary care specialties. We concur with the criteria specified for determining the allocation of funded slots: quality, geographic distribution of graduates, and underserved minority representation. In addition, we support the guarantees that payments will be made directly to the training programs.

Definition of Primary Care

As this committee considers issues related to the physician supply we urge that the concept of primary care not be trivialized. A primary care physician (or generalist physician) provides definitive care to the unselected patient at the point of first contact. As defined by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature, and care that includes the coordination of other health services. Such a physician will have been trained specifically to provide primary care services, usually through completion of a residency in family practice, general internal medicine or general pediatrics.

Primary care physicians devote the substantial majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that the personal primary care physician serves as the first point of contact for substantially all of the patient's medical and health care needs.

In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of conditions requiring specialized care, and the provision of health promotion and disease prevention services.

Occasionally, individuals who are not trained as primary care physicians will provide patient care services within the domain of primary care. These limited primary care providers may be physicians from other specialties, nurse practitioners, or physician assistants. Such providers may focus on patient care needs related to prevention, health maintenance, acute care, chronic care, or rehabilitation.

The contribution of limited primary care providers may be important to specific patients. However, the absence of a full scope of training in primary care and limited practice skills in providing the full range of primary care services requires that such providers work in close consultation with fully trained primary care physicians. Effective systems of primary care will use limited primary care providers as adjuncts to the health care team with primary care physicians taking responsibility for the total care of each patient.

We note with some concern that the Clinton bill includes obstetrician-gynecologists in the definition of primary medical care. The fact that ob-gyns

provide certain services that are within the domain of primary care is well recognized. Furthermore, we recognize that many women have the majority of their health care encounters with ob-gyns during certain periods of their lives. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in ob-gyns. We note that the ob-gyn literature clearly acknowledges the limited role of ob-gyns in the provision of primary care.

As the definition of primary care is used in the President's health reform plan, it dictates a substantial redirection of training funds. Because the role of ob-gyn in primary care is limited, we are very concerned that efforts to improve access to primary care will be compromised by including ob-gyns in the definition of primary care. Increasing the training funds for ob-gyns will not improve substantially the number of providers of primary care services. Furthermore, including ob-gyns in the definition of primary care suggests that there are available many more primary care physicians than is, in fact, the case.

Title VII Family Medicine Programs

Title VII, Section 747, of the Public Health Service Act is the only federal program that provides funding for training family physicians and for establishing and maintaining departments of family medicine. In fiscal year 1994, funding for family medicine programs was increased by \$9 million to \$47.2 million, after several years of funding cuts. Because we need more family physicians, and other generalists, in rural counties I urge you to continue your support for this federal program.

Liability Reform

Reform of the liability system at the federal level would go a long way to solving the problem of access to OB services in rural areas. Both my partner and I have

been sued, unsuccessfully, but we have chosen to continue providing obstetrical services because we are only a few of the physicians in our county who will.

According to a 1988 *Medical Economics* study, 62 percent of family physicians gave up obstetrics between 1982 and 1988. A recent report from the Institute of Medicine states that many rural providers have given up OB services, due, in large part, to the high cost of malpractice insurance and fear of lawsuits. A recent study, *The North Carolina Obstetrics Access and Professional Liability Study: A Rural-Urban Analysis*, concluded that 46% of rural physicians compared to 16.7% urban physicians, decreased their obstetric services due to fear of a malpractice lawsuit.

Concerns about malpractice contribute to the growth in health care costs directly through excessive premiums, awards, and administrative payments and indirectly through the induced practice of defensive medicine. The provisions in the President's plan addressing malpractice concerns are consistent with those supported by the Academy, but it is silent on two effective strategies that have been utilized in state malpractice reforms: the limit of payments for non-economic damages and a statute of limitations for filing a claim. Additionally, we believe that the proposed alternative dispute resolution (ADR) mechanism would add more administrative burden than it would eliminate.

The Academy suggests the ADR mechanism be modified so that at the completion of the alternative dispute process, if one of the parties in the dispute wishes to challenge the outcome, he or she may do so in court. However, if the decision rendered in court is less favorable than that in the alternative dispute resolution, he or she would pay all legal fees.

We recommend that the statute of limitations be modified so that a claim must be filed within two years from the date that the alleged injury should have reasonably been discovered, but in no event more than four years from the time of alleged injury. In the case of alleged injury to children under age six, a claim must be filed within four years from the date that the alleged injury should have been reasonably discovered.

In regard to limits on non-economic damages a limit of \$250,000 should be established.

Conclusion

If we are serious about providing quality care, and especially quality OB and prenatal care to our populations, then we must train more family physicians, provide professional liability reform, and develop a reimbursement system that will encourage young physicians to move to rural communities where their services are so greatly needed.

As a rural family physician, I am gratified to make recommendations to improve health care in rural areas, and look forward to the time when rural physicians, like myself and others in my county, can benefit from those improvements.

Senator DODD. Dr. Meyer.

Dr. MEYER. Thank you, Senator Dodd and members of the committee, for the opportunity to join you at this hearing. I come before you today both as a provider of adolescent health care in New York City and as director of maternal and child health care services for the New York State Department of Health.

It is not long ago that no one asked what the health care needs of adolescents should be. It was assumed that adolescents would be cared for as grown-up children or as young adults, and it is indeed a milestone that you both invited a member of the adolescent community and the adolescent health care provider community to testify today.

Our teenagers have unique health care needs. Adolescence is an "Alice-in-Wonderland/Manchild in the Promised Land/ Catcher in the Rye" sort of experience, all rolled into one. It is the uniqueness of this developmental experience and the intense pressures brought on teens that shape their health care needs.

It is sobering to stop and look for a moment at some of the numbers. In New York State, the three leading causes of death for 15- to 24-year-olds are injuries, homicides, and suicides, all self-generated causes. Every 3 days, five young people die of injuries, nearly five die of homicide, and two commit suicide. Every 45 minutes, an adolescent is abused. One-third of child abuse cases in New York State occur to children between the ages of 10 and 18. More than one in every 10 youth is a school dropout. Every 33 minutes, a youth under age 18 is arrested for murder, rape, robbery, or assault.

And there is more. Every 10 minutes, a teenager becomes pregnant. Almost every 6 hours, an adolescent under the age of 19 becomes infected with HIV. Every hour, a case of gonorrhea is diagnosed; every 12 hours, a case of syphilis.

We know that 43 percent of adolescents attending school, grades 7 through 12, have smoked cigarettes, 75 percent have used alcohol, and 16 percent have used cocaine.

Now, those of us who do care for adolescents know well some of the statistics averted that you spoke to. We know about children who do not become pregnant who otherwise might; we know about children who avoid the juvenile delinquency system, and we know about children who remain in school and stay with families who otherwise might not.

Today's youth are indeed tomorrow's adults, and investing in their future, helping them to reach productive and hopeful lives, is certainly one of the most important goals our Nation can have.

I want to focus my remaining time on three things: One, the fact that all adolescents are at risk of serious health problems simply because of the nature of normal adolescent development; the meaning of preventive services in adolescence; and, as you already mentioned, the importance of a flexible schedule for adolescent visits.

To understand adolescent health needs, we must consider what is going on in normal adolescent development. During adolescence, there are more profound physical changes going on than in any other time in our lives.

There is also the task of achieving one's own identity, often not without a search and struggle that may include rejection of family

expectations and values. Identity formation includes a strong bonding with peers and achieving a sexual identity. Teenagers also begin to think differently, expanding their conceptual and experiential horizons to embrace new ideologies, new commitments. They strive to find a meaningful role in society, which may be much more difficult today than it was a century ago. And none of it comes easily.

Normal teenagers encounter many risks to their health and well-being in this process of growing up. Because of this, preventive health services for adolescents must be broad and flexible in scope. The major manifestations of morbidity and mortality in adolescence are consequences of normal development. The sense of invulnerability associated with newfound strength and potency leads to injuries. Emotional liability may be experienced as personal violence. Exploration of new feelings can lead to sexual activity without precautions against unwanted pregnancy or sexually-transmitted diseases, and expanding cognitive horizons may lead to experimentation with mind-altering substances and drugs. Even the frequently asked or wondered questions for adolescents, "Am I normal?" can have profound consequences.

A comprehensive approach to adolescent health with an emphasis on preventive services is vital to reaching out and supporting our teenagers in today's complex world. The essence of effective health care for adolescents is to make it relevant to everything else going on in their lives, as Joseph Medlin made so clear to us this morning. This means a broad definition of health care which includes a range of health supportive services, such as outreach, care counseling, education, vocational counseling, and a health system infrastructure able to facilitate and coordinate these linkages.

The concept of providing services in a community-based setting like a school-based clinic is an excellent one that recognizes the importance of caring for adolescents within the context of their lives. We must be sure to support our community-based providers currently reaching out to these youth.

It is also critical to allow a flexible schedule for preventive health care, forming a therapeutic alliance with an adolescent, gaining his trust and confidentiality, generally takes time. It may mean more than one preventive visit a year for some adolescents, and achieving preventive health care will mean more visits for some, fewer for others, depending on the circumstances they face. An arbitrary cap limiting these services will be detrimental to the goals we are trying to achieve.

Adolescents with chronic illnesses have an even greater need for preventive health visits. They struggle to stay well, their lives are often more restricted, and they face unique barriers in making the transition to adulthood.

It is important to recognize that adolescents often use health care opportunities as an entryway to bring their worlds to a caring person. It may be easier to come in with a physical complaint, like a stomach ache or a chest pain, than it is to start an awkward conversation.

Remembering the grim statistics we live with every day, our health system must be ready to reach out and serve teens wherever they are. I am hopeful and encouraged that a vigorous and healthy

debate has begun about what the health care system should be for adolescents.

I commend President and Mrs. Clinton for their leadership on this issue and this committee for addressing these issues.

Thank you for the opportunity to share thoughts with you.

[The prepared statement of Dr. Meyer follows:]

PREPARED STATEMENT OF MONICA MEYER

Senator Kennedy, Senator Dodd, and other Members of the Labor Committee, thank you for opportunity to join you at this hearing. I am Monica Meyer, and I come before you today both as a provider of adolescent health care in New York City, and as director of maternal and child health for the New York State Department of Health.

It is not long ago that no one asked what the health care system for adolescents should be. It was assumed that adolescents would be cared for like grown up children or young adults. It is indeed a milestone that you have invited both a member of the adolescent community, and a spokesperson for adolescent health care providers to speak about the content of adolescent care.

Our teenagers have unique health care needs. Adolescence is an Alice in Wonderland/Manchild in the Promised Land/Catcher in the Rye sort of experience—all rolled into one. It is the uniqueness of this developmental experience, and the intense pressures brought to bear on teens, that shape adolescent health care needs.

It is sobering to stop and look at the numbers for a minute: In New York State, the 3 leading causes of death for 15-24 year olds are injuries, homicide and suicide. Every three days 5 young people die of injuries; almost 5 die of homicide, and 2 commit suicide. Every 45 minutes an adolescent is abused, and over one third of all cases of child abuse involve children between 10 and 18 years old. More than one in every ten youths is a school drop-out, and thirty two thousand drop out of school every year. Every 33 minutes a youth under age 18 is arrested for murder, assault, rape or robbery.

There is still more. Every 10 minutes a teenager becomes pregnant; over 27,000 adolescents gave birth last year. About every 6 hours a child 19 years or younger becomes infected with HIV—for a total of 4 every day. Every hour an adolescent is diagnosed with gonorrhea, every twelve hours a case of syphilis. Forty three percent of adolescents attending school grades 7-12 report having smoked cigarettes; 75% have used alcohol; and 16% have used cocaine.

Today's youth are tomorrow's adults. Investing in their futures, and helping them to reach healthy, productive and hopeful lives is one of the most important goals our nation can have.

I want to focus on three things today: the fact that ALL adolescents are at risk of serious health problems because of the nature of normal adolescent development; the meaning of preventive services in adolescents; and the importance of a flexible schedule for adolescent visits.

To understand adolescent health needs, you must consider what's going on in normal adolescent development. During adolescence there are more profound physical changes occurring more quickly than at almost any other time in our lives. There is also the task of achieving one's own identity, often not without a search and a struggle that may include rejection of family expectations and values. Identity formation includes a strong bonding with peers, and developing a sexual identity. Teenagers also begin to think differently, expanding their conceptual and experiential horizons to embrace new ideologies and new commitments. They strive to find a meaningful role in society—a challenge that may be more difficult in today's world than it was a century ago.

None of it comes easily, and normal teenagers encounter many risks to their health and well-being in this process of growing up. Because of this, preventive health services for adolescents must be broad and flexible in scope. The major manifestations of morbidity and mortality in adolescence are consequences of normal development: the sense of invulnerability associated with newly-acquired strength and potency leads to injuries; emotional lability may be expressed as personal violence; exploration of new feelings can result in sexual activity without precautions against unwanted pregnancy or sexually transmitted diseases, including HIV infection. Expanding cognitive horizons may lead to experimentation with mind-altering substances and drugs. Even the frequently asked or wondered question "Am I normal?" can have profound consequences.

A comprehensive approach to adolescent health, with an emphasis on preventive services, is vital to reaching out and supporting our teenagers in today's complex

world. The essence of effective health care for adolescents is to make it relevant to everything else going on in their lives. This means a broad definition of health care which includes a range of health-supportive services such as outreach, peer-counseling, education, vocational counseling, and a health system infrastructure able to facilitate and coordinate these linkages. The concept of providing services in community settings like school-based clinics is an excellent one that recognizes the importance of caring for adolescents within the context of their lives. We must be sure to support our community-based providers currently reaching out to these youth. We are firmly committed to this in New York State as an essential step forward in protecting teen health.

It is also important to allow a flexible schedule for preventive health care. Forming a therapeutic alliance with adolescents and gaining their trust generally takes time, and may mean more than one preventive visit a year for some adolescents. Achieving preventive health care will mean more visits for some, fewer for others, depending on the circumstances facing each youth. An arbitrary cap limiting these services will be detrimental to the goals we are trying to achieve.

Adolescents with chronic illnesses like diabetes, sickle cell disease, and cystic fibrosis often have an even greater need for preventive health visits. These teens struggle to stay well, their lives may be more restricted, and they face unique barriers in making the transition to adulthood.

It is important to recognize that adolescents often use health care opportunities as an entry way to bring their worlds to a caring person. It may be easier to come in with a physical complaint like a stomach ache or chest pain than to start an awkward conversation. Remembering the grim statistics we live with every day, our health system must be ready to reach out and serve teens wherever they are—in our schools, community centers, and offices. Nothing could be more important.

I am hopeful and encouraged that a vigorous and healthy debate has begun on meeting the health needs of adolescents. I commend President Clinton for his leadership on this issue, and this Committee for its attention to these concerns. Thank you for the opportunity to share these thought with you today. I am happy to take any questions you may have.

Senator DODD. Thank you very much, Dr. Meyer. Your testimony was very helpful.

Since all of you in one way or another deal with all of these issues, if I address a question to any one of you, I invite each of you to comment if you feel so inclined.

And by the way, Dr. Pearson, I thank you for this report card. It is helpful and an interesting view of the various ideas that are out there on how children would be affected by health care reform. We will place that in the record with your testimony, and I will utilize it.

And Dr. Meyer, I have your statement. Your statistics are very helpful. I know statistics can cause the eyes to glaze over, but those are pretty poignant, and I think with your permission, I will use them in other venues to make the point.

One of the major issues for me, anyway, is this universality question. There are a lot of other debates, and we will get to some of those questions, but in the absence of universality, I am really worried about us dealing with any of these issues very effectively. Particularly in rural settings, for instance, if you do not have universal coverage, this is a pointless effort in many ways.

I wonder if you could comment on the significance of that particular aspect of this, because the Breaux plan, or the Cooper plan, Phil Gramm's plan, just do not deal with that particular aspect, and I do not know if people appreciate or understand that significant difference between what is being offered as an alternative. For practicing physicians, how critically important is this issue?

Dr. PEARSON. Absolutely crucial. Without it, we will not have health care reform.

Senator DODD. You really could not call it reform in the absence of that.

Dr. PEARSON. No, I think not. Again, we have tried to do that in the past, and we find that when people are faced with tough decisions about paying for insurance or paying for the mortgage, they choose the obvious. And I do not think you can have meaningful health care reform, particularly for children, unless they are covered, and even covering all adults does not ensure that children are covered.

Senator DODD. Is there any dissent on that? Basically, among this panel, there is no disagreement on that?

Dr. HALFON. Just to add, again, on the cost, to look at it in economic terms, by having universal coverage and by having everybody onboard, then you are able to start to look at the real costs of what the system are, and you do not have a lot of dangling extra programs and nets out there that are costing you lots of money, people coming into the emergency rooms that are getting paid for one way or another when they show up, who are not going to primary care because that is not available to them. Three percent of children in the United States regularly use emergency rooms as their source of sick care, and that is largely because they do not have primary care providers. If we do not provide universal coverage, there is no way of efficiently starting to organize the system to start to bring down costs.

So that besides the equity issue is the efficiency issue.

Dr. MEYER. One other observation. School-based clinics really are sources of universal coverage. Students do use those clinics for real prevention, and they do because the issue of can I pay for me health care is not what is on the table. It really is when you have a health care need or think about health care, you can walk in the door and be served.

Senator DODD. You have anticipated a question that I was going to ask you about that. Do you still see the need for school-based clinics, even with universal coverage, if these children would have the opportunity of going elsewhere. I know some of these questions seem obvious, but you appreciate we are building a record here—why is maintenance of a school-based health care system important, even with a universal system?

Dr. MEYER. Having a health security card is not what is going to enable many people to feel comfortable walking in the door to our health care system. What school-based clinics, and some other community-based providers, have enabled to happen is they have made people comfortable to come in and get their health care needs taken care of. And I think Joseph was a perfect spokesperson for that this morning. So when you feel comfortable, that is when you will get health care.

Dr. ANDERSON. I would like to address both of those issues. I look at universal coverage not necessarily just from the benefit of patients receiving care. I look at it from manpower issues. There are parts of our provider organizations that provide much of that care to noncovered individuals and receive no reimbursement for that. In the emergency room in downtown Detroit, those emergency room physicians are paid an hourly wage to be there.

I have been an emergency room doctor every other night for 17-1/2 years, and I do not get paid to come in at 3 o'clock in the morning unless there is a source of revenue from that patient, and there usually is not at that time of the morning. That is why there is nobody who wants to come out and help me do rural practice.

A community-based system in my county would be very, very administratively expensive. It would be nice, 35 hours a week, to have somebody there, but who is going to take care of those people the rest of the time? I am sure there are some communities, some schools, where it would be nice if the student who had a problem could have a one-on-one relationship with the counselor in that clinic. But I feel, at least for the rural States, that that is not going to come close to meeting any of the problems that we are talking about.

Senator DODD. Well, let me ask you about that, because I hear what you are saying, but I suspect an awful lot of those people who are showing up at those emergency rooms are showing up because they have reached a crisis situation.

Dr. ANDERSON. I am afraid that is wrong. Every doctor in my county will see anybody who calls, and most of us will see them within 36 hours. That is how we practice. I do not know how we developed that way, but every doctor sees any patient who calls—and we will see them in our office, because if we do not see them in the office, we see them in the emergency room at night. Who wants to do that?

Senator DODD. I meant the person who comes around at 3 o'clock in the morning.

Dr. ANDERSON. Let me tell you what frequently happens. Let us say it is a 25-year-old guy who comes in with a cough. I usually do not go and see a 25-year-old guy with a cough. I have to see an 18-month-old kid with fever and vomiting—it may be meningitis, he may be critically ill. I will say to that 25-year-old person that I will give him a couple of antibiotic pills, and I will see him in my office at 9 o'clock. Does he show up? Usually not.

So I am saying that we are available for patients, and they choose for various reasons—probably one of them is they do not want to be asked to pay the bill to come to the emergency room—and I am not trying to be materialistic here or anything, but we are out there, literally working 90 hours a week, trying to take care of our patients, and we will see any of them in our office—and if they cannot pay, they cannot pay—we take care of them.

Senator DODD. I know it is hard. And it is not just a rural issue. I was thinking that at 3 o'clock a.m., you would get someone showing up with a real crisis. I was at the Bridgeport Hospital the other day. I went by and spent some time in the emergency room. Last year, they saw 52,000 people who came through the emergency room doors. Their estimates are that 80 percent of those people had no business being there.

The irony of ironies is they will sit there and tell them exactly where they can go, where the alternatives are, that they can be seen, and so on, and people just are not making those calls. I mean, they are just not doing it.

Dr. ANDERSON. They are not. You made the comparison earlier about that we have the emergency room, and then we could have

a minor place nextdoor. Well, that is okay if you have a volume of patients, but in rural areas, you just cannot do that.

Senator DODD. I understand, but how would you deal with it?

Dr. ANDERSON. Oh, I do not think there is any way to control that entirely. But in time, with managed care—right now, for 30 years, we have had a system based on paying for procedures, not on outcomes. Managed care, although it may not be perfect, as the doctors have commented, is based on outcomes, because if you have poor outcomes, then you have more expense. There are some really innovative things being done in managed care to go out and get that patient who will not come in for her ob checks—pay her cab fare, and so on. France, I guess, was giving them \$1,000 if they would come in for only four prenatal visits. We see most of our girls 12 or 14 times.

So it is going to be difficult. There are going to be some people who are going to be recalcitrant to training, but now is the time to start, and we have to start with universal coverage so that it impacts the manpower, at least in the inner city and the rural areas, in the way I have discussed.

Senator DODD. Well, you anticipated one of my questions, but let me ask you something related to it. I will ask you, and then others can comment. As a Catholic, I am always intrigued by the problems presented with the diminishing supply of parish priests, and I was thinking of it in the context of primary care physicians. I do not know if there is any correlation here at all—

Dr. ANDERSON. I do not, either.

Senator DODD [continuing]. But maybe if they would allow one to get married and the others not, or something like that, we might solve the problem. [Laughter.] And frankly, I suppose there is a corollary, because one of the things that is happening is that now the church is expanding its rules to such an extent that laypeople are performing a lot of the functions that, when I grew up as a kid, would be unheard of for anyone other than an ordained priest to perform.

What about the expanding permissiveness of health care providers who are not M.D.s, not necessarily even R.N.s, to begin to start to move into a lot of these areas and begin to pick up some of the problems that we are talking about here? How receptive are you as practicing physicians going to be about having people who have less academic backgrounds than you to accept a constituency coming into your fields?

Joel and I employ three physicians' assistants. We have two satellite offices. And my sister is a nurse clinician. So very definitely, there is a role, a real role, for nonphysician providers in an integrated system where they are properly supervised by a primary physician—and that could be pediatric, it could even be an internal medicine-type situation. But you realize that primary care is that initial contact with the undifferentiated patient. That patient with chest pain may have a cold, may have cancer, may have anxiety and depression. So these primary care providers, nonphysician-trained people, need to be supervised, and so they should be in integrated systems.

Senator DODD. I do not disagree with that.

Doctor Halfon, I saw you shaking your head.

Dr. HALFON. I agree completely with the point of the integrated systems. I think that we can have well-differentiated systems if we define what primary care is. Primary care is the first contact care. It is supposed to be comprehensive. It is supposed to provide a full range of services. Defining what comprehensive is depends on the population you are dealing with. Primary care for inner city children whose mothers are chemically dependent, who have been born drug-exposed, or for a foster child, or for a kid with chronic illness, is very, very different than for a well child in a middle-class home. What defines comprehensive services for those high-risk, vulnerable children are a much broader set of services.

And as Dr. Brazelton was talking about earlier, you need not just a primary care provider, but you need a primary care team, a team of people that can range from someone who does not have as much specialty training in pediatrics or child care, can be a nurse practitioner or physician assistant, but you also need that pediatrician; you oftentimes in those high-risk situations might need someone specifically trained in developmental and behavioral pediatrics, or you might need someone who is a mental person, as part of the primary team. If 60 percent of your population is coming in with mental health problems, they should be part of the team. You should not have to go through all kinds of levels of having to prove that.

So we have to think about primary care in a much broader way. Primary care does not equal general practice. Primary care does not equal one-size-fits-all for all populations.

Senator DODD. I do not disagree; you are preaching to the choir here a bit on this. But I have got to tell you, too—and you will not get any more sympathetic Member of Congress when it comes to kids and these issues—I think that violence is a health issue. There is a lot more recognition of that now that people know what the cost is for one gunshot wound, around \$30,000—and that is not a fatal wound, either. So I do relate to what you say, but I tell you, I have an awful problem trying to convince, with the finite resources we are talking about here, that drunk driving and the suicide issues and all these questions belong as part of a basic benefit package. It is a very difficult issue, when we have so many other problems we have got to wrestle with here, to try to have included.

So at some point, I think we are going to need some help in the wish list. We all have wish lists, particularly from the pediatric community, and I am going to insist upon adolescents being included in this—if you cannot do everything for me, Senator, here are some of the priority categories—so I have some help in making my pitch. If I make it as sort of a huge grab bag, I am afraid I will not get much. I think if I can come in with more of a rifle shot and say, look, if you cannot do everything for me, here is what I need for you to do immediately; as you expand the benefits package over the next 3 to 5 to 7 to 10 years, here is what I want to see included. I would like to get all of it in the first year, but if you cannot do all of it for me in the first year, here is what I need to have you do for me as we expand this effort. I am really going to need that guidance from you as we put that together.

Dr. MEYER. The heart of preventive health care is health education, and that has traditionally been the role that nurses and nurse practitioners have carried out. Again, what we see in the

school-based clinic is the integration of health education with health care; nurse practitioners in partnership with primary docs do a wonderful job of that.

Senator DODD. And that is why it is such a natural thing.

I want to turn to Dr. Pearson, because I know you have a flight to catch——

Dr. PEARSON. Just one thing. I do not think you were calling for barefoot practitioners to go out, as they do in China, to deliver health care to our rural people.

Senator DODD. No, no, no.

Dr. PEARSON. I think quality is crucial.

Senator DODD. I do not disagree.

Dr. PEARSON. And if we begin to talk in terms of so equating health care with economics that we accept the second class care of children, we will not have done our job.

Senator DODD. No, I am not saying that at all.

Dr. PEARSON. I know that.

Senator DODD. But I do think it is awfully important to start looking at areas where just as a practical matter, it is hard to get people to go into those areas.

Dr. PEARSON. Yes. I think the crucial thing is the health care assessment of the community. And in some communities, a school-based clinic would be terrific. In other places, it would be redundant. And I think that is what our job will be.

Senator DODD. Tell me a bit about Bright Futures.

Dr. PEARSON. It was a joint project by MCH and HCFA, recognizing that the various benefit packages and schedules had been really kind of pulled from the air. So they assembled 150 people, and they were not just physicians or pediatricians; they were all sorts of child advocates. And they labored for more than a year and a half, asking what should the basic schedule of benefits and the basic schedule of care be for children from birth to adolescence. And they labored hard and have come forth with, I think, really a very strong statement of what it should be.

And I think it will be essentially the crucial, if you will, benchmark by which we say, sure, there ought to be a 2-week visit, and here is what will be done in the 2-week visit with respect to prevention, anticipatory stuff, and that sort of thing. Then you can sell it, and then you can begin to make some judgments about outcome.

So I think this is probably a very, very important document, and fortunately, it is emerging just at the time when I think we need it in the health care reform debate.

Senator DODD. Terrific. In addition to the Jameson and Weir study, we will see that that gets incorporated here.

Dr. HALFON. Could I just say one thing about Bright Futures?

Senator DODD. Yes, Dr. Halfon.

Dr. HALFON. I actually wrote the 2-week visit; I was one of people on the Bright Futures panel. The thing about Bright Futures is that Bright Futures also sets a standard of quality and outcomes for children that is much broader than we are currently providing, and it is much broader than what most HMOs or indemnity insurance plans provide. It sets a standard for what health care for kids should be. And I think in looking at that, it is going to be very hard

to make Bright Futures fit with any of the plans that are being provided, even though that is what we should be shooting for.

Senator DODD. Thank you.

Dr. PEARSON. Senator, I am going to have to leave, and I apologize.

Senator DODD. I know, Howard. It is good to see you. Thanks so much for being here. We will be talking to you a lot before this is all over with.

Dr. Meyer, you heard Senator Wellstone and Senator Kassebaum and others ask and receive, I thought, a very good answer from not only Joseph, but also the particular physician associated with his school-based clinic, talking about the quality of the people in these clinics and the acceptance of what a school-based clinic is, rather than being seen as something to be avoided, it is something that becomes part of the normal involvement of students, whether they go in for immunizations or for pregnancy tests.

How important do you think that is, and what can be done to at least maximize the possibility of that becoming a situation? Is there a way in which you do that, or is it just that we get lucky at some point because we get the right people?

Dr. MEYER. I was actually very surprised to hear what Senator Kassebaum said about school-based clinics. My own experience is that the stigma in school-based clinics comes from the outside, not from the inside.

We have 140 school-based clinics in New York State. They are applauded by the schools, by the community, and by the providers and the consumers. They have to be formed in partnership with the community; it does not work if standards for a school-based clinic are set by people who come in to do school health.

Senator DODD. Yes, I agree.

Dr. MEYER. But when that partnership happens, they become very accepted. We have several school-based clinics in rural areas where the schools cannot speak more about the value of the clinics because students are missing less school, because in the rural community, for some of those kids to get to another source of health care—and these are underserved communities I am speaking to—but to get to another source of health care would mean missing more than a day of school.

So I think the problem is more from lack of understanding than from those individuals who do the clinics, and the kids are the ones who bring in their peers.

Senator DODD. I think you are probably right. I think the idea that a child is seeking out someone else and talking to someone else about highly personal matters—even the ones who do not necessarily get into the ones that are most sensitive—is a threatening notion for parents who are having a difficult time accepting the independence of growing children. I suspect a lot of the hostility—well, “hostility” is the wrong word—the sort of hesitancy or unease about this may be generated by that. Maybe I am talking completely off the top of my head and not making any sense at all, but I have a sense where some of it may come from.

Dr. ANDERSON. Not being aware of the rural community you talked about, that community where the student has to go some length to get care, I would say there are probably some 19, 21, 35,

and 85-year-old people who have the same problem. Would it not be better—maybe the school-based clinic is the idea—but would it not be better to put a satellite office there with a primary care physician, probably a family physician, or maybe a physician's assistant under the supervision of a family physician, to meet the needs of the whole community, not just the school-age individual—because if what you are telling me is right, then the whole community needs care.

Senator DODD. Well, that may be. And again, I think we want to be careful about one size fitting all; it depends upon where you are whether it can work. I sort of agreed with Dr. Pearson when he said you do not want to build in redundancies unnecessarily.

But I do subscribe to the notion that, because kids break away from the family, but not have achieved economic independence or maturity yet, something in between becomes an attractive alternative. In many cases, kids have trouble actually having to go to their parents and saying, "I would like to go to the doctor." Parents want to know why, and the kids do not want to say, so you get a breakdown. I think there is some real value in having a unique situation for that adolescent community, particularly since we have so many problems associated with them from the health perspective. But anyway, it is a good discussion to have as we go through all of this.

I could virtually keep all three of you here for the entire day. I find your testimony so interesting and so worthwhile. So I may submit some additional questions for you in writing.

I just want to end on this note, and I want you to know this. First of all, Dr. Anderson, we are so jammed up around here in the past few days—we have the crime bill on the floor, we have 10,000 other things going on here—that we have not had the kind of membership here that we might otherwise. Do not misunderstand that for lack of interest in this subject matter.

The chairman of this committee, for instance, cares deeply about it, but coincidentally, the clinic access issue, one of the hot issues, is on the floor today, despite the fact that we scheduled this hearing weeks ago. He could not plan that or anticipate it; that is the way it happened.

But I want to let you know that I have great respect for, and this committee cares a lot about these issues. Just to give you an idea, the Subcommittee on Children is made up of virtually every member of the full committee. There is no other subcommittee that falls into that category. It is because in the last few years, people have really developed a great interest in what happens to families and kids. That was not true when I arrived in the Senate 14 years ago. There was no committee. I had to form a caucus, an ad hoc caucus—I could not even get money for it—for children. And today, it is the largest subcommittee of this committee, and we have had some great success.

So the absence of other members here should not in any way be interpreted as a lack of interest at all. Quite the contrary.

For my part, I just want to tell you—and I think I am going to have a lot of support on this committee and elsewhere—that I have great respect for those who are going to focus on the elderly and their needs, and for those who are going to be focusing on the phys-

ically disadvantaged. I am not in any way suggesting I will not be supportive—but this is what I am going to focus on the issue of primary care, family practitioners, children, and pregnant women. I am going to insist that any bill that comes out of this Congress, whenever it happens—a year from now, a year and a half from now, whenever it is—that this constituency be very, very visible in that legislation. And I promise you that will be the case.

I would not make too many promises about a lot of things that could happen around here, but this one, I promise you. When it comes to prevention, I will try to see to it that children from prenatal to 21 are going to be very much a part of this entire effort, and to the largest extent possible, I will see that they are included overall. And your testimony today really helps me in making that case. As we go through this process, every panel of witnesses I hear, I do not care where they come from, I will focus on these particular issues and the importance of them.

And I feel particularly lucky because we have got a President and a First Lady who care deeply about these issues as well. We are not debating threshold questions of whether or not this is important, or whether or not this is something we ought to be doing. They are trying to wrestle with a lot, but we are not arguing about whether or not this is something we ought to be doing. So that is a major asset as we go forward.

You have given me some great ideas and some great suggestions for things for us to look at and to include, and we will have some additional hearings on these particular sets of issues, and we may do just a hearing on adolescent issues and just a hearing on some of these reports and studies and take a look at them more closely, and encourage a good, broad debate.

And you can be guaranteed, Dr. Anderson, that not only am I going to be interested in rural health care, even though I do not come from a rural State, but I can promise you that I look at that caucus of Senators who come from rural States, and there is not going to be a health care package that gets out of this place that rural health care is not a part of. I just promise you that people like Kent Conrad and Tom Daschle and Larry Pressler and Nancy Kassebaum—I can go down the list—certainly, Jim Jeffords, who is a cosponsor of the Clinton bill—they care deeply about it as well. So you can feel pretty confident. But I think it is very important to stay in touch with them on these issues and share your thoughts and views as to how we can make it work, because if there are any shortcomings, it will be more out of mistake than intentionally doing something different.

Dr. ANDERSON. Certainly. That is good.

Senator DODD. So we urge you to stay involved.

I want to again thank Senator Kennedy, the chairman of the committee. I saw him earlier at the vote. He really did want to be here. And his staff, I thank for their help today as well, particularly to Deborah Von Zinkernagel, who was very, very helpful in putting this all together.

So again, my thanks to our witnesses and to the audience for being here. We will leave the record open for some additional questions or comments that may occur to you later today or the rest of this week that you may wish to submit to us as well.

With that, the committee will stand adjourned.
[Whereupon, at 1:25 p.m., the committee was adjourned.]



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